

**STATE FISCAL YEAR 2020**  
**MODEL PURCHASE OF SERVICE PROVIDER AGREEMENT FOR**  
**MOUNTAIN HEALTH PROMISE**

**BETWEEN**

**STATE OF WEST VIRGINIA**  
**DEPARTMENT OF HEALTH AND HUMAN RESOURCES**  
**BUREAU FOR MEDICAL SERVICES**  
**BUREAU FOR CHILDREN AND FAMILIES**

**AND**

**Aetna Better Health of West Virginia**

**STATE OF WEST VIRGINIA**  
**DEPARTMENT OF HEALTH AND HUMAN RESOURCES**  
**PURCHASE OF SERVICE PROVIDER AGREEMENT**

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**STATE OF WEST VIRGINIA**  
**DEPARTMENT OF HEALTH AND HUMAN RESOURCES**  
**PURCHASE OF SERVICE CONTRACT**

**ARTICLE I: STANDARD WEST VIRGINIA TERMS**

This CONTRACT is made and entered into by and between the STATE OF WEST VIRGINIA, DEPARTMENT OF HEALTH AND HUMAN RESOURCES (DHHR), BUREAU FOR MEDICAL SERVICES (BMS), hereinafter referred to as the "Department," and Aetna Better Health of West Virginia, hereinafter referred to as the "Managed Care Organization (MCO)."

WHEREAS, the Department has conducted an open solicitation for the services of an MCO interested in entering into a Contract to provide risk-based comprehensive health services, children's residential care services, and Socially Necessary Services (SNS) administration to select West Virginia Medicaid managed care enrollees who are in foster care or, are receiving adoption assistance and those children eligible under the Serious Emotional Disorder (SED) Home and Community Based Services (HCBS) waiver program; and

WHEREAS, the MCO has demonstrated the ability to provide risk-based comprehensive health services in compliance with the program terms and requirements; and

WHEREAS, the Department has approved the MCO to provide risk-based comprehensive health services, children's residential care services, and SNS to select West Virginia Medicaid managed care enrollees who are in foster care or are receiving adoption assistance; and

WHEREAS, the Department has approved the MCO to provide risk-based comprehensive health services, and Medicaid HCBS waiver to select West Virginia Medicaid managed care enrollees who are eligible and enrolled through the Department's SED waiver; and

WHEREAS, the MCO must serve as an Administrative Services Organization (ASO) for the administration of SNS and has demonstrated the ability to oversee the utilization management of such services and oversight of the providers that administer them; and

NOW THEREFORE, in consideration of the foregoing recitals and of the mutual covenants contained herein, the Department and the MCO hereby agree as follows.

**1. GENERAL TERMS AND CONDITIONS**

Written MCO responses to a Request for Proposal, (including the Department's written responses to oral and written questions, appendices, amendments, and addenda) and/or to other formal requests by the Department for information and documents are hereby incorporated by reference as part of the Contract having the full force and effect as if specifically contained herein. In the event of a conflict in language between this Contract and other documents mentioned above, the following order of precedence will apply:

- A. The terms of this Contract; and

## B. MCO responses to the RFP.

In construing this Contract, whenever appropriate, the singular tense will also be deemed to mean the plural and vice-versa. Titles of paragraphs used herein are for the purpose of facilitating ease of reference only and will not be construed to be a part of this Contract.

### **2. CONTRACT TERM**

The initial term of this Contract is expected commence on March 1, 2020 and run through June 30, 2020, at which time the Contract may be renewed, at the option of the Department, for three (3) successive one (1)-year periods. This Contract may be renewed upon the mutual written consent of the Department and the MCO, with written approval of the State of West Virginia, Department of Administration Purchasing Division and the Attorney General's office (Attorney General approval is as to form only). The Centers for Medicaid and Medicare Services (CMS) must review and approve this Contract or any amendments to thereof in accordance with 42 CFR 438.806.

Any request for renewal should be submitted to the State of West Virginia, Department of Administration Purchasing Division thirty (30) days prior to the expiration date of the initial Contract term or appropriate renewal term. DHHR will be responsible for submitting the request but the MCO assumes responsibility for submitting any documentation required for a renewal. A Contract renewal must be in accordance with the Contract Terms and Conditions of the original Contract. Renewal of this Contract is limited to successive one (1) year periods or multiple renewal periods of less than one (1) year, provided that the multiple renewal periods do not exceed thirty-six (36) months in total. Automatic renewal of this Contract is prohibited. Attorney General's approval may be required for the certain Contract Terms and Conditions proposed by the Department.

In the event the Department opts to renew the Contract, notice must be sent to the MCO thirty (30) calendar days prior to the end of the current Contract period. In the event a decision is made not to renew the Contract, notice will also be sent to the MCO thirty (30) calendar days prior to the end of the current Contract period.

Any modification to this Contract will be subject to the terms of the RFP with the capitation rates being adjusted to reflect the corresponding Fiscal Year.

Using actuarially sound standards, the Department will calculate capitation payments to the MCO on the annual basis for the State Fiscal Year (SFY) time period (i.e., SFY21 begins July 1, 2020, and ends June 30, 2021).

Notwithstanding the foregoing, the State of West Virginia, Department of Administration Purchasing Division approval is not required on the Department's delegated or exempt purchases.

### **3. ENTIRE AGREEMENT**

This Contract (including all provisions incorporated by reference in Section 1 and any appendices, exhibits, rate matrices and schedules hereto) constitutes the entire agreement between the parties. No amendment or other modification changing this Contract will have any

force or effect unless it is in writing and duly executed by the parties. Said modification will be incorporated as a written amendment to the Contract.

#### **4. CONTRACT ADMINISTRATION**

This Contract will be administered for the State by DHHR. The Assistant to the Deputy Secretary will serve as Contracting Officer upon the execution of the Contract. The Contracting Officer will be the primary contact for all matters related to this Contract.

#### **5. NOTICES**

Any notice required under this Contract must be deemed sufficiently given upon delivery, if delivered by hand (signed receipt obtained) or three (3) days after posting if properly addressed and sent certified mail return receipt requested. Notices must be addressed as follows:

Managed Care Organization

Department

Jeff Wiseman  
Assistant to the Deputy Secretary  
West Virginia Department of Health and Human Resources  
1 Davis Square, Suite 100E  
Charleston, WV 25301  
304-558-6052 (office phone)

[Jeff.A.Wiseman@wv.gov](mailto:Jeff.A.Wiseman@wv.gov)

Said notices will become effective on the date of receipt or the date specified within the notice, whichever comes later. Either party will be notified of an address change in writing.

All questions, requests, and other matters related to the administration of this Contract must be addressed with Jeff Wiseman to be considered.

## **ARTICLE II: GENERAL CONTRACT TERMS FOR MANAGED CARE ORGANIZATIONS**

### **1. DEFINITIONS**

As used throughout this Contract, the following terms will have the meanings set forth below.

Abuse – provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

Administrative Services Only (ASO) – a contract to administer benefits, such as claims processing, claims review, and network access.

Actuary – an individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board. In this Contract, Actuary refers to an individual who is acting on behalf of the State when used in reference to the development and certification of capitation rates.

Administration for Children and Families (ACF) – a division within the federal Department of Health and Human Services (DHHS) responsible for promoting the economic and social well-being of families, children, individuals and communities.

Adoption Assistance – a social services program, under Title XX of the Social Security Act (SSA), that provides cash assistance and/or social services to adoptive parents who adopt "hard to place" foster care children who were in the custody of a local department of health and human resources or a child placing agency licensed by West Virginia.

Advance Directive – a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated.

Adverse Benefit Determination – the MCO's decision to deny or limit authorization or payment (in whole or in part) for health care services, including new authorizations and previously authorized services; the MCO's reduction, suspension, or termination of a previously authorized service; the MCO's failure to provide services as required by the Contract; the MCO's failure to resolve grievances or appeals within the timeframes specified in this Contract; or the MCO's denial of a request by an enrollee who resides in a rural area with only one (1) MCO to receive out-of-network services; or the denial of an enrollee's request to dispute a financial liability, including copayments.

Adverse Childhood Experiences (ACEs) – stressful or traumatic events, including abuse and neglect. They may also include household dysfunction such as witnessing domestic violence or growing up with family members who have substance use disorders. ACEs are strongly related

to the development and prevalence of a wide range of health problems throughout a person's lifespan, including those associated with substance misuse.

Agency for Healthcare Research and Quality (AHRQ) – the lead Federal agency charged with improving the safety and quality of America's health care system. AHRQ develops the knowledge, tools, and data needed to improve the health care system and help Americans, health care professionals, and policymakers make informed health decisions.

Appeal – a request for a review of the MCO's adverse benefit determination as defined in this Contract and 42 CFR 438.400(b) (1-7).

Authorized Agent – any corporation, company, organization, or person or their affiliates, not in competition with the MCO for the provision of managed care services, retained by the Department to provide assistance with administering its MCO program or any other matter.

Authorized Representative – a person authorized by the enrollee in writing to make health-related decisions on behalf of an enrollee, including, but not limited to Enrollment and Disenrollment decisions, filing Appeals and Grievances with the Contractor, and choice of a Primary Care Physician (PCP). The Authorized Representative is the Parent, Adoptive Parent or legal guardian for a child. For an adult, this person is the legal guardian (guardianship action), health care power of attorney, other person that has power of attorney, or another signed HIPAA compliant document indicating who can make decisions on behalf of the enrollee. For Foster Care enrollees, the Authorized Representative is the child's Child Protective Services (CPS) worker at BCF.

Behavioral Health Services – services used to treat a mental illness, behavioral disorder and/or substance use disorder which necessitates therapeutic and/or supportive treatment, such services include but not limited to psychological and psychiatric services.

Bureau for Children and Families (BCF) – a division within the West Virginia DHHR responsible for the operation of a number of programs that affect families and children, including day care centers, adult care providers, early childhood services and the fostering and adoption of West Virginia children. Bureau staff located in the county offices are responsible for the day-to-day delivery of services such as child and adult protective services, foster care, adoption, financial assistance, and food stamps.

Bureau for Medical Services (BMS) – a division within the West Virginia DHHR that serves as is the designated single state agency responsible for the administration of the State's Medicaid program and providing access to appropriate health care for Medicaid-eligible individuals.

Bureau for Public Health (BPH) – a division within the West Virginia DHHR that directs public health activities at all levels within the state to fulfill the core functions of public health: the assessment of community health status and available resources; policy development resulting in proposals to support and encourage better health; and assurance that needed services are available, accessible, and of acceptable quality.

Business Continuity Plan (BCP) – a plan that provides for a quick and smooth restoration of the MCO information system after a disruptive event. BCP includes business impact analysis, BCP development, testing, awareness, training, and maintenance. This is a day-to-day plan.

Capitation Payment – a payment the State makes periodically to the MCO on behalf of each beneficiary enrolled under this Contract and based on the actuarially sound capitation rate for the provision of covered services. Reimbursement for this contract will be designed using a braided funding stream, with Medicaid and BCF dollars being braided to develop a monthly capitation payment for holistic care. The State makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment.

Cardiac Rehabilitation – a comprehensive outpatient program of medical evaluation, prescribed exercise, cardiac risk factor modification, and education and counseling that is designed to restore enrollees with heart disease to active, productive lives.

Care Coordination – organizing patient care activities and sharing information among all the participants concerned with an enrollee’s care to achieve safer and more effective care. Through organized care coordination, an enrollee’s needs and preferences are known ahead of time and communicated at the right time to the right people to provide safe, appropriate, and effective care.

Caregiver – the BCF-authorized caretaker for a child in Foster Care and may be a Foster Parent(s), relative(s), or staff of a twenty-four (24)-hour childcare facility.

Care Management – a Defined as a team-based, person centered approach to effectively managing patients’ medical, social and behavioral conditions. Care Management must include, at a minimum, the following:

- High-risk care management (e.g., high utilizers / high-cost beneficiaries);
- Care Needs Screening;
- Identification of enrollees in need of care management;
- Development of Care Plans (across priority populations);
- Development of comprehensive assessments (across priority populations);
- Transitional care management: management of enrollee needs during transitions of care (e.g., from hospital to home);
- Care Management for special populations (including pregnant women and children at-risk of physical, development, or socio-emotional delay);
- Chronic care management (e.g., management of multiple chronic conditions);
- Coordination of services (e.g., appointment/wellness reminders and social services coordination/referrals);
- Management of unmet health-related resource needs and high-risk social environments;
- Management of high-cost procedures (e.g., transplant, specialty drugs);
- Management of rare diseases (e.g., transplant, specialty drugs);
- Management of medication-related clinical services which promote appropriate medication use and adherence, drug therapy monitoring for effectiveness, medication related adverse effects; and
- Development and deployment of population health programs.

Case Management – a person-centric, collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual’s health needs through communication and available resources to promote Quality cost-effective outcomes. Case Management serves as a means for achieving enrollee wellness and autonomy through advocacy, communication, education, and identification of services and resources. Interventions are undertaken with the purpose of helping enrollees receive appropriate care. Case Management is distinguished from Utilization Management in that it is voluntary and it is distinguished from Disease Management by its intensity and focus on any disease(s) or condition(s) of the enrollee.

Centers for Medicare and Medicaid Services (CMS) – a division within the federal Department of Health and Human Services responsible for the oversight of the Medicare program, the federal portion of the Medicaid program and Children's Health Insurance Program, the Health Insurance Marketplace, and related quality assurance activities.

Child Abuse - The Federal Child Abuse Prevention and Treatment Act (CAPTA) (42 U.S.C.A. § 5106g), as amended by the CAPTA Reauthorization Act of 2010, defines child abuse and neglect as, at minimum:

- "Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation"; or
- "An act or failure to act which presents an imminent risk of serious harm."

Child Protective Services (CPS) Worker – a professional social worker who provides assistance to children and families by helping them address psychological and social problems related to child abuse and neglect. CPS Workers provide interventions, prepare treatment plans and case plans, and perform duties related to various social services program areas such as CPS, Foster Care, and Adoption Assistance.

Children and Youth with Special Health Care Needs (CYSHCN) – those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

Children’s Bureau (CB) – the ACF office providing federal oversight for child welfare; focusing on improving the lives of children and families through programs that reduce child abuse and neglect, increase the number of adoptions, and strengthen foster care.

Choice Counseling – the provision of information and services designed to assist enrollees in making managed care enrollment decisions; it includes answering questions and identifying factors to consider when choosing between managed care and fee-for-services (FFS). Choice counseling does not include making recommendations for or against enrollment into an MCO.

Cold-Call Marketing – any unsolicited personal contact by the MCO with a potential enrollee for the purpose of influencing the potential enrollee to enroll in that particular MCO. Cold Call Marketing includes, without limitation:

- Unsolicited personal contact with a potential enrollee outside of an enrollment event, such as door-to-door or telephone marketing.
- Any marketing activities at the enrollment events where participation is mandatory.
- Any other personal contact with a potential enrollee if the potential enrollee has not initiated the contact with the MCO.

Common Area (Marketing) – any area in a provider’s facilities that is accessible to the general public. Common areas include, without limitation: reception areas, waiting rooms, hallways, etc.

Complaint – an expression of dissatisfaction made about an MCO decision or services received from the MCO when an informal grievance is filed; some complaints may be subject to appeal.

Consultant/Consultant Affiliates – any corporation, company, organization, or person or their affiliates retained by the Department to provide assistance in this project or any other project; not the MCO or Subcontractor.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) – an enrollee survey program of AHRQ measure patient experience with health plans, providers, and health care facilities. This survey is conducted annually by the MCO and results are submitted to the External Quality Review Organization (EQRO).

Co-payment – a required payment made by an MCO enrollee for certain covered services or medical supplies in addition to a payment made by the MCO for that same covered service or medical supply.

Corrective Action – an improvement in a business process that may be required by the Department to correct or resolve a deficiency in the MCO’s processes or actions.

Corrective Action Plan (CAP) – a detailed written plan that may be required by the Department to correct or resolve a deficiency in the MCO’s processes or actions.

Cost-Sharing – copays that the MCO enrollee is billed at the time of service. Copays are determined by the Department based on the enrollee’s family income. There are no premiums or deductibles under the West Virginia Medicaid program.

Covered Services (Contract Services) – health care services the MCO must arrange to provide to Medicaid enrollees, including all services required by this Contract and state and federal law, and all Value-Added Services negotiated by the MCO and the Department.

Critical Incident - Critical incidents are serious in nature and pose immediate risk to the health, safety, or welfare of the member or others. These incidents require in-depth investigation, an expedited timeline, and possibly additional resources.

Day – except where the term “business days” is expressly used, all references in this Contract will be construed as calendar days.

Default Enrollment (Assignment) – a process established by the Department through the CMS waiver authority to assign an enrollee who has not selected an MCO to an MCO.

Department – the West Virginia Department of Health and Human Resources (DHHR).

Department of Administration (DOA) Purchasing Division – the West Virginia agency responsible for the timely, responsive, and efficient procurement of goods and services for state government.

Department of Health and Human Services (DHHS) – the federal department dedicated to enhancing and protecting the health and well-being of all Americans by providing for effective health and human services and fostering advances in medicine, public health, and social services. It oversees CMS and ACF federal agencies.

Direct Mail Marketing – any materials sent to potential enrollees by the MCOs or their agents through U.S. mail or any other direct or indirect delivery method.

Disability – a physical or mental impairment that substantially limits one (1) or more of an individual’s major life activities, such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and/or working.

Disabled Person or Person with Disability – a person under sixty-five (65) years of age, including a child, who qualifies for Medicaid services because of a disability.

Durable Medical Equipment (DME) – certain medical equipment or supplies a provider orders for an enrollee’s use such as wheelchairs, crutches, diabetic supplies, hospital beds, oxygen equipment and supplies, nebulizers, and walkers.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) – Medically Necessary services, including interperiodic and periodic screenings, listed in Section 1905(a) of the Social Security Act. EPSDT entitles Medicaid-eligible infants, children, and other Medicaid enrollees under age twenty-one (21) to any treatment or procedure that fits within any of the categories of Medicaid-covered services listed in Section 1905(a) of the Social Security Act if that treatment or service is necessary to “correct or ameliorate” defects and physical and mental illnesses or conditions.<sup>1</sup>

Emergency Care – includes inpatient and outpatient services needed immediately and provided by a qualified Medicaid provider for emergency medical, behavioral health, or dental conditions where the presenting symptoms are of sufficient severity that a person with average knowledge of health and medicine would reasonably expect the absence of immediate medical attention to result in placing their health or the health of an unborn child in immediate jeopardy, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part; and that are

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<sup>1</sup> Section 1905(r)(5) of the Social Security Act

needed to evaluate or stabilize an emergency medical condition. These include accidental injury and poison related problems and complaints that may be indicative of serious, life threatening medical problems, such as chest or abdominal pain, difficulty breathing or swallowing, or loss of consciousness. If the patient presents at the hospital emergency department and requests an examination, a nurse triage screening is always allowed. In the case of behavioral health services, emergency care means those clinical, rehabilitative, or supportive behavioral health services provided for behavioral health conditions or disorders for which a prudent layperson with an average knowledge of health and medicine, could reasonably expect to result in risk of danger to a person's self or others if not immediately treated. These include, but are not limited to, crisis stabilization treatment services.

Emergency Dental Condition – a dental or oral condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson possessing an average knowledge of health and medicine requires immediate services for relief of symptoms and stabilization of the condition; such conditions may include severe pain, hemorrhage, acute infection, traumatic injury to the teeth and surrounding tissue, or unusual swelling of the face or gums.

Emergency Medical Condition – conditions where the presenting symptoms are of sufficient severity that a person with average knowledge of health and medicine would reasonably expect the absence of immediate medical attention to result in placing the individual's health or the health of an unborn child in immediate jeopardy, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part.

Emergency Medical Transportation – ambulance services for an emergency medical condition.

Emergency Room Care – emergency services an enrollee receives in an emergency room.

Emergency Services – covered inpatient and outpatient services that are: given by a qualified provider; and are needed to evaluate or stabilize an emergency medical condition.

Encounter Data – procedure-level data on each contact between an enrolled individual and the health care system for a health care service or set of services included in the covered services under the Contract.

Enrollee – a recipient/member who has been certified by the State as eligible to enroll under this Contract, and whose name appears on the MCO enrollment information which the Department will transmit to the MCO every month in accordance with an established notification schedule. An enrollee may also refer to an individual who has been deemed eligible for Medicaid, but not yet enrolled with a specific MCO..

Enrollment Broker – the entity contracted by the Department to conduct outreach and enrollment of eligible West Virginia Medicaid managed care enrollees. The enrollment broker is not applicable under this contract as a single MCO contract.

Excluded Services – health care services that the MCO does not pay for or cover.

External Quality Review – the analysis and evaluation by an EQRO, of aggregated information on quality, timeliness, and access to the health care services that the MCO or its Subcontractors furnish to Medicaid beneficiaries.

External Quality Review Organization (EQRO) – the entity contracted by the Department to conduct periodic independent studies regarding the quality of care delivered to West Virginia Medicaid managed care enrollees. EQRO must meet the competence and independence requirements set forth in 42 CFR 438.354, and perform external quality review, other EQR-related activities as set forth in 42 CFR 438.358, or both.

Family First Prevention Services Act (FFPSA) – the law that reforms Title IV-E and Title IV-B of the Social Security Act and federal child welfare financing providing services to families at risk of entering the child welfare system.

Family Planning Services – those services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy. These services include: health education and counseling necessary to make informed choices and understand contraceptive methods; limited history and physical examination; laboratory tests if medically indicated as part of decision making process for choice of contraceptive methods; diagnosis and treatment of sexually transmitted diseases (STDs) if medically indicated; screening, testing, and counseling of at-risk individuals for human immunodeficiency virus (HIV) and referral for treatment; follow-up care for complications associated with contraceptive methods issued by the family planning provider; provision of contraceptive pills /devices/supplies; tubal ligation; vasectomies; and pregnancy testing and counseling.

Family Service Plan (FSP) – a plan developed for and in consultation with the family to document the strategy to reduce the risk, needs, and contributing influences which require Youth Services intervention.

Fiscal Agent – an entity performing administrative service functions, including provider payment, enrollee eligibility, and capitation payment functions, for the managed care program under a separate Contract with the Department.

Formal Grievance – a written expression of dissatisfaction with the conduct or action of an MCO other than those subject to appeal.

Foster Care – a twenty-four (24) hour substitute care for children placed away from their parents or guardians and for whom the Title IV-E agency (WV DHHR BCF) has placement and care responsibility. This includes, but is not limited to, placements in foster family homes, foster homes of relatives, group homes, emergency shelters, residential facilities, child care institutions, and pre-adoptive homes.

Foster Parent – a substitute caregiver who assumes the daily caretaking responsibilities for children in BCF custody who have been placed in their home.

Fraud – an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Gift (Marketing) – any promotional item or incentive offered by an MCO to enrollees or potential enrollees.

Grievance – an expression of dissatisfaction, either in writing (formal) or orally (informal), regarding any aspect of service delivery provided or paid for by the MCO, other than those MCO adverse benefit determinations that are subject to appeal. The term grievance also refers to the overall system that includes grievances and appeals handled at the MCO level and access to the State fair hearing process.

Grievance Process – the procedure for addressing an enrollee’s grievances and complaints.

Grievance System – includes a grievance process, an appeals process, and access to the State’s fair hearing system.

Habilitation Services and Devices – health care services and devices that help an individual keep, learn, or improve skills and functioning for daily living such as occupational therapy, speech therapy, and other services for people with disabilities in inpatient and/ or outpatient settings.

Health Assessment – Health assessment is a process involving systematic collection and analysis of health-related information on patients for use by patients, clinicians, and health care teams to identify and support beneficial health behaviors and mutually work to direct changes in potentially harmful health behaviors. Health assessments are not intended to be diagnostic tools and they are not complete health histories; instead, they aim to be one method to engage patients in their own health, leading to better health choices and improved health behaviors in the long term.provides.

Health Home – a designated provider (including provider that operates in coordination with a team of health care professionals) or a health team selected by an eligible individual to provide health home services as defined in Section 1945 of the Social Security Act. Chronic condition health homes are available for eligible individuals with certain chronic conditions. West Virginia’s requirements for health homes are defined in the Medicaid State Plan.

Health Plan – another term used to refer to an MCO. Also referred to as a Plan.

Home and Community Based Services (HCBS) – services provided in the individual’s home or community to targeted population groups, such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses and provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings.

Home Health Care – health care services a person receives at home, including limited part-time or intermittent skilled nursing care, home health aide services, occupational therapy, speech therapy, medical social services, DME, medical supplies, and other services.

Home Visitation Program – a program of DHHR’s BCF within the Office of Maternal, Child and Family Health that involves partnerships at federal, state and community levels to assist families in meeting their parenting goals. Programs are available at no cost to families across the state. Programs are delivered by local home visitors who have received extensive training in evidence-

based curriculums. These in-home visits can be initiated during pregnancy and continue to age three to five. Using a family-centered, asset-building approach, families determine what issues they want to address. The intent of the program is to partner with families so children grow up healthy, strong and ready to learn.

Hospice Services – services to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has a terminal illness and is expected to have six (6) months or less to live. A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.

Hospitalization – care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care – care in a hospital that usually does not require an overnight stay.

Individualized Service Plan (ISP) – a plan developed by a Multidisciplinary Treatment Team (MDT) for a child who is involved in court proceedings either because of child abuse and neglect, status offense, or delinquency proceedings.

Informal Grievance – an oral expression of dissatisfaction other than those subject to appeal.

Information Security Plan – a written MCO compliance plan with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and The Health Information Technology for Economic and Clinical Health Act (HITECH Act).

Key Personnel – those staff as outlined within Article II, Section 5.10.

Liquidated Damages – reasonable estimates of the Department’s projected financial loss and damage resulting from the MCO’s non-performance.

Long-acting Reversible Contraceptives (LARC) – nonpermanent methods to prevent pregnancy lasting more than one cycle. LARC includes intrauterine devices (IUDs) and contraceptive injections and implants.

Managed Care Initiative – West Virginia’s Medicaid managed care program, as described in the current state plan and federal waiver and amendments, and approved by CMS. This may include one or more MCOs and voluntary or mandatory enrollment options in a given geographic area.

Managed Care Organization (MCO) – an Health Maintenance Organization (HMO) entity licensed to do business in the State of West Virginia, that has, or is seeking to qualify for, comprehensive risk contract, and that is:

1. A Federally qualified HMO that meets the advance directives requirements of 42 CFR 489, Subpart I; or
2. Any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions:

- a. Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity; and
- b. Meets the solvency standards of 42 CFR 438.116.

Managing Employee – a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency, in accordance with 42 CFR 455.101.

Marketing – any communication, from the MCO to a Medicaid-eligible person who is not enrolled in the MCO, that can reasonably be interpreted as intended to influence such person to enroll in that particular MCO's Medicaid program, or either to not enroll in, or to disenroll from, another MCO's Medicaid program. Marketing does not include communication to a Medicaid beneficiary from the issuer of a qualified health plan, as defined in 45 CFR 155.20, about the qualified health plan.

MCO Readiness Review – the assurances made by a selected MCO and the examination conducted by the Department, or its agents, of MCO's ability, preparedness, and availability to fulfill its obligations under this Contract, State Plan, and federal waiver.

MCO Service Area – all the counties included in any Department's defined service area within which the MCO has been contracted to provide MCO services.

Medicaid – the West Virginia Medical Assistance Program operated and funded by the Department pursuant to Title XIX, Social Security Act (42 U.S.C. §1396 et seq.), and related State and Federal rules and regulations (same as Medical Assistance).

Medicaid Management Information System (MMIS) – an integrated group of subsystems used for the processing, collecting, analysis, and reporting of information needed to support Medicaid and Children's Health Insurance Program (CHIP) functions including claims and payments.

Medicaid Policy – collectively refers to documents and other written materials including the State Medicaid plan, program instructions, attendant provider manuals, program bulletins, and all published policy decisions issued by BMS. These materials are available through BMS.

Medicaid Program Provider Manuals – service-specific documents created by the Bureau for Medical Services to describe policies and procedures applicable to the program generally and that service specifically.

Medical Assessment – an initial medical evaluation completed for enrollees in Foster Care when they have newly entered or are re-entering Foster Care. The Medical Assessment must follow the requirements set forth in Medicaid EPSDT program, and include dental, hearing, and developmental screenings. A trauma assessment must also be performed at this time. Assessments must be completed within thirty (30) calendar days.

Medical Loss Ratio (MLR) – the ratio of the numerator (as defined in accordance with 42 CFR 438.8(e)) to the denominator (as defined in accordance with 42 CFR 438.8(f)) and subject to any applicable adjustments, as provided under this Contract and Appendix G.

Medically Necessary – refers to services or supplies for diagnosing, evaluating, treating, or preventing an injury, illness, condition, or disease, based on evidence-based clinical standards of care. Medically necessary services are accepted health care services and supplies provided by health care entities, appropriate to evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standard of care. Determination of medical necessity is based on specific criteria.

For Medicaid covered medical or other health services to children under twenty-one (21) it refers to services which: a) are reasonable and necessary to prevent illness or medical conditions, or provide early screening, interventions, and/or treatment for conditions that cause suffering or pain, cause physical deformity, or limitation in function, cause illness or infirmity, endanger life, or worsen disability; b) are provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's medical conditions; c) are consistent with the diagnosis of the conditions; d) are no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, efficiency, and independence, and e) will assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account the functional capacity of the individual, and those functional capacities that are appropriate for individuals of the same age.

Mountain Health Trust (MHT) – the name of West Virginia's Medicaid mandatory managed care program for Temporary Assistance to Needy Families (TANF) and TANF-related children and adults who are eligible to participate in managed care.

Multidisciplinary Team (MDT) – a team consisting of persons representing various disciplines associated with key components of the Foster Care assessment process. The MDT serves as the central point for decision making during the life of a case and develops the case plan. The purpose of the MDT meetings is to review the outcome and recommendations of the provider related to the assessment of the Foster Care enrollee and the enrollee's family.

National Committee for Quality Assurance (NCQA) – the independent organization that accredits MCOs, managed behavioral health organizations, and accredits and certifies Disease Management programs.

Network – doctors, hospitals, facilities, and other licensed health care professionals who contract with an MCO to give care to its enrollees.

Non-Emergency Services – any care or services that are not considered emergency services as defined in this Contract. This does not include any services furnished in a hospital emergency department that are required to be provided as an appropriate medical screening examination or stabilizing examination and treatment under section 1867 of the Social Security Act.

Non-Participating Provider – a doctor, hospital, facility, or other licensed health care professional who has not signed a contract or had a contract signed on his/her behalf agreeing to provide services to the MCO's enrollees.

Open Panel – PCPs who are accepting new patients for the MCO.

Overpayment – money paid to a Provider by an MCO for a claim or claims, which exceeds the amount which should have been paid by the MCO.

Participating Provider – a doctor, hospital, facility, or other licensed health care professional who has signed a contract or had a contract signed on his/her behalf agreeing to provide services to the MCO's enrollees.

Patient-Centered Medical Home – “a health care setting that facilitates partnerships between individual patients and their personal physicians and, when appropriate, the patients’ families and communities. A patient-centered medical home integrates patients as active participants in their own health and well-being. Patients are cared for by a physician or physician practice that leads a multidisciplinary health team, which may include, but is not limited to, nurse practitioners (NP), nurses, physician assistants (PA), behavioral health providers, pharmacists, social workers, physical therapists, dental and eye care providers and dieticians to meet the needs of the patient in all aspects of preventive, acute, chronic care and end-of-life care using evidence-based medicine and technology. At the point in time that CMS includes the NP as a leader of the multidisciplinary health team, this state will automatically implement this change (§16-29 H-9 of the West Virginia State Code).”

Patient Protection and Affordable Care Act (PPACA) – the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), together known as the Affordable Care Act (ACA).

Periodicity Schedule – the requirements and frequency by which periodic screening services are provided and covered. Schedule must meet current standards of pediatric medical and dental practice and specify screening services applicable at each stage of the enrollee's life, beginning with a neonatal examination, up to the age at which an individual is no longer eligible for EPSDT services.

Person Centered Service Planning Team (PCSPT) – a team formed when a member enrolled in the SED waiver turns fifteen (15) and that is responsible for developing measurable outcomes that guide the member toward transition or graduation from waiver enrollment.

Persons with Special Health Care Needs (SHCN) – individuals who have chronic physical, developmental, behavioral or emotional conditions. Such needs are of a type or amount beyond that generally required by individuals in that age range.

Physician Services – health care services that a licensed medical physician provides or coordinates.

Post-stabilization Services – services subsequent to an emergency medical condition that a treating physician views as Medically Necessary after an enrollee's condition has been stabilized in order to maintain the stabilized condition or to improve or resolve the enrollee's condition.

Potential Enrollee – a Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific MCO.

Pregnant Women or Pregnancy-Related Services – all women receiving related services and services for other conditions that might complicate the pregnancy, unless specifically identified in the Medicaid State Plan as not being related to the pregnancy. This includes counseling for cessation of tobacco use and services during the postpartum period. The pregnancy period for which these services must be covered includes the prenatal period through the postpartum period (including the sixty (60)-day postpartum period following the end of pregnancy; see 42 CFR 440.210(a)(3)).

Prescription Drug Coverage – health insurance that helps pay for prescription drugs and medications. Prescription drug coverage is not provided by the MCO. The Department provides outpatient prescription drug coverage directly to Medicaid enrollees.

Prescription Drugs – drugs and medication that, by law, require a prescription.

Primary Care Physician – a doctor who directly provides and coordinates health care services to MCO enrollees.

Primary Care Provider (PCP) – a specific clinician responsible for treating and coordinating the health care needs of certain enrollees.

Primary Services – basic or general health services rendered by general practitioners, family practitioners, internists, obstetricians, and pediatricians.

Prior Authorization/Preauthorization – approval granted for payment purposes by the MCO for its active, specified enrollees, or the Medicaid Program to a provider to render specified services to a specified enrollee.

Provider – an individual or entity that is engaged in the delivery of health services, or ordering or referring for those services, who meets the requirements of the West Virginia Medicaid Program and is enrolled in the MCO's network.

Psychiatric Residential Treatment Facilities (PRTF) – a separate, standalone entity providing a range of comprehensive psychiatric services to treat the psychiatric condition of residents under age twenty-one (21) years on an inpatient basis under the direction of a physician. The purpose of such comprehensive services is to improve the resident's condition or prevent further regression so that the services will no longer be needed. (42 CFR §483.352, subpart D of part 441).

Pulmonary Rehabilitation – individually tailored multidisciplinary approach to the rehabilitation of enrollees who have pulmonary disease.

Qualified Residential Treatment Program (QRTP) – a specific category of a licensed non-foster family home setting with a trauma-informed treatment model that is designed to address the needs, including clinical needs as appropriate, of children with serious emotional or behavioral

disorders or disturbances and, with respect to a child, is able to implement the treatment identified for the child by the required thirty (30) day assessment of the appropriateness of the placement.

Regulation – a Federal or State agency statement of general applicability designed to implement or interpret law, policy, or procedure.

Rehabilitation Services and Devices – health care services and devices that help an individual keep, get back, or improve skills and functioning for daily living that have been lost or impaired because he was sick, hurt, or disabled including occupational therapy, speech therapy, and psychiatric rehabilitation services in inpatient and/ or outpatient settings.

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

Residential Placement – an Out of Home Placement setting designed to meet the needs of children and youth with behavioral, emotional and mental health needs that prevent them from being able to reside in a less structured family home setting. A residential treatment facility offers a structured physical environment and a treatment program designed to help children improve their ability to function in multiple areas of life.

Risk – the possibility of monetary loss or gain by the MCO resulting from service costs exceeding or being less than payments made to it by the Department.

Routine Care – basic primary care services including the diagnosis and treatment of conditions to prevent deterioration to a more severe level, or minimize/reduce risk of development of chronic illness or the need for more complex treatment.

Serious Emotional Disturbance (SED) – a diagnosable mental, behavioral, or emotional disorder at any time during the past year of sufficient duration to meet diagnostic criteria specified within the Diagnostic Statistical Manual (DSM) and that resulted in functional impairment which substantially interfered with or limited the child’s role or functioning in family, school, or community activities.

Serious Emotional Disturbance (SED) Waiver – a Medicaid home and community-based services waiver authorized under §1915(c) of the Social Security Act. The SED waiver provides additional services to those provided through the Medicaid State Plan to children from three (3) up to age twenty-one (21) with an SED. It allows the State to provide an array of home- and community-based services that enable children who would otherwise require institutionalization to remain in their home and community.

Service Authorization – (also Prior Authorization); includes an enrollee’s request for the provision of a service.

Skilled Nursing Care – services from licensed nurses in a enrollee’s own home or in a nursing home.

Socially Necessary Services (SNS) – Services provided to improve relationships and social functioning, with the goal of preserving the individual’s tenure in the community or the integrity of the family or social system. Socially necessary services are interventions designed to maintain or establish safety, permanency and well-being for targeted populations.

Specialist – a provider who focuses on a specific kind of health care, such as a surgeon or a cardiologist.

Start Date – the date the Contract for services becomes effective.

Subcontract – any written agreement between the MCO and another party to fulfill any requirements of this Contract.

Subcontractor – party contracting with the MCO to perform any services related to the requirements of this Contract. Subcontractors may include, without limitation, affiliates, subsidiaries, and affiliated and unaffiliated third parties.

Subcontractor Monitoring Plan – a written plan describing how obligations, services, and functions performed by the MCO’s Subcontractor will be reviewed to ensure that such obligations, services, and functions are performed to the same extent that they were performed by MCO.

Supplemental Security Income (SSI) – a Federal income supplement program designed to help aged, blind, and disabled people with little or no income by providing cash to meet basic needs for food, clothing, and shelter.

Systems Quality Assurance Plan – a written plan developed by the MCO that describes the processes, techniques, and tools that the MCO will use for assuring that the MCO information systems meet the Contract requirements.

Targeted Case Management (TCM) – the coordination of services to ensure that eligible Medicaid enrollees have access to a full array of needed services including the appropriate medical, educational, or other services. TCM is responsible for identifying an enrollee’s problems, needs, strengths, and resources; coordinating services necessary to meet those needs; and monitoring the provision of necessary and appropriate services. This process is intended to assist enrollees and as appropriate, their families, in accessing services which are supportive, effective and cost efficient. TCM activities ensure that the changing needs of the Medicaid enrollee are addressed on an ongoing basis and that appropriate choices are provided from the widest array of options for meeting those needs. TCM is not a direct service. TCM is composed of a number of federally designated components: Needs assessment and Reassessment; Development and Revision of TCM Service Plan; Referral and Related Activities; and Monitoring and Follow-up.

Temporary Assistance to Needy Families (TANF) – the federally funded program that provides assistance to single parent families with children who meet the categorical requirements for aid.

Tertiary Services – highly specialized medical services administered in a specialized medical facility.

Third Party – any individual entity or program which is or may be liable to pay all or part of the expenditures for Medicaid furnished under a State Plan.

Title XIX – refers to Title XIX of the Social Security Act codified at 42 United States Code Annotated Section 1396 et. seq., including any amendments thereto (see Medicaid).

Transition of Care – the movement of patients between health care practitioners and/or settings as their condition and care needs change during the course of a chronic or acute illness. For Foster Care enrollees, and Adoption Assistance enrollees, Transition of Care planning may involve activities or needs related to an enrollee’s placement in BCF custody or, transition from Mountain Health Trust (MHT) Medicaid or commercial health plans to the Specialized Managed Care Plan for Children and Youth program; changes in Residential Placement; aging out of Foster Care; or transitioning out of Specialized Managed Care Plan for Children and Youth to MHT or West Virginia Health Bridge (WVHB) Medicaid managed care or a commercial health plan.

Trauma Assessment – an in-depth exploration of the nature and severity of the traumatic events experienced directly or witnessed by the child, the sequence of those events, and the current trauma-related symptoms to determine the best type of treatment for that specific child. The provider must use a BCF approved assessment tool to identify the types and severity of symptoms the child is experiencing. The comprehensive Trauma Assessment must provide recommendations to coordinate services and meet the child’s needs.

Trauma Assessment Screening – a tool used by providers to ascertain an individual’s trauma history and trauma related symptoms. This information can help identify individuals at risk of developing more pervasive and severe symptoms of traumatic stress and inform treatment options.

Value-Added Services – services that include additional value benefits that are actual health care services, benefits, or positive incentives that will promote healthy lifestyles and improve health outcomes among enrollees.

West Virginia Health Bridge (WVHB) – the name of West Virginia’s mandatory managed care program for adults eligible for the Medicaid Alternative Benefit Plan (ABP).

Withhold Arrangement – a payment mechanism under which a portion of a Capitation Payment is withheld from an MCO and a portion of or all of the withheld amount will be paid to the MCO for meeting measures specified in the Contract. The measures for a Withhold Arrangement are distinct from general operational requirements under the Contract. Arrangements that withhold a portion of a Capitation Payment for noncompliance with general operational requirements are contractual remedies and not a Withhold Arrangement.

Urgent Care – refers to circumstances in which the individual requires prompt medical attention for the care and management of a significant physical or mental disorder, but there is no immediate threat to the individual’s life.

## **2. DELEGATIONS OF AUTHORITY**

The West Virginia DHHR shall be responsible for administering this contract. The West Virginia Bureau for Medical Services (BMS) within the DHHR is the single state agency responsible for administering the Medicaid program. The West Virginia BCF within DHHR is responsible for the oversight of children within the State's custody, and the administration of SNS. No delegation by either party in administering this Contract will relieve either party of responsibility for carrying out the terms of the Contract.

## **3. FUNCTIONS AND DUTIES OF THE MANAGED CARE ORGANIZATION**

The MCO agrees to perform the functions and duties and fulfill the responsibilities described in Article III, Statement of Work.

## **4. FUNCTIONS AND DUTIES OF THE STATE**

### **4.1 Eligibility Determination**

The Department will determine the initial and ongoing eligibility for services of each enrollee or potential enrollee under this Contract.

### **4.2 Enrollment**

The Department will conduct MCO enrollment process in accordance with 42 CFR 438. 54. The Department, either directly or through its designee, will process all enrollments into the MCO. The Department will notify the MCO of such enrollments by means of a daily and monthly enrollment roster report which explicitly identifies those additions who were not enrolled in the MCO during the previous month. The roster will be provided via secure File Transfer Protocol (FTP) or electronic media, and will be delivered by the Department to the MCO as soon as possible following the MMIS cut-off date for the month, but not later than the last business day before the end of the month.

### **4.3 Enrollee Assignment**

All eligible children and youth will be enrolled in a single contracted MCO. Enrollees may choose to remain in fee-for-service (FFS) as their alternative delivery system option under this contract. For SNS, the MCO shall have administrative responsibilities for all enrollees eligible for services, independent of their enrollment status with the MCO for Medicaid-covered services.

### **4.4 Voluntary and Involuntary Disenrollment**

All MCO enrollees will remain continuously enrolled throughout the term of this Contract, except in situations where clients lose their Medicaid eligibility, are admitted to a skilled nursing facility (SNF) or nursing facility, voluntarily disenroll, or are re-categorized into a Medicaid coverage category not included in the managed care delivery system. The Department will notify the MCO of all disenrollment, by means of a monthly enrollment roster report which explicitly identifies terminations from enrollment and the cause of the disenrollment (e.g. loss of Medicaid eligibility, change in eligibility status to a coverage code not included in the managed care initiative, voluntary switching to FFS or other causes).

#### 4.5 Capitation Payments to Managed Care Organization

Payment to the MCO will be based on the enrollment data transmitted from the Department's eligibility vendor to its Fiscal Agent each month for MCO-eligible members.

The MCO must notify BMS in writing of any inconsistency between enrollment and payment data no later than within forty-five (45) calendar days from the day inconsistency was determined by the MCO. BMS agrees to provide to the MCO information needed to determine the source of the inconsistency within ten (10) business days after receiving written notice of the request to furnish such information. BMS will recoup overpayments or reimburse underpayments as soon as administratively possible. The adjusted payment (representing reinstated enrollees) for each month of coverage will be included in the next monthly capitation payment, based on updated MCO enrollment information for that month of coverage.

Any retrospective adjustments to prior capitations will be made in the form of an addition to or subtraction from the current month's capitation payment. Positive adjustments are particularly likely for newborns, where the MCO may be aware of the birth before BMS.

In full consideration of Contract services rendered by the MCO, the Department agrees to pay the MCO monthly payments based on the methodology specified in Appendix B. Department capitation payments to the MCO will apply to the time period March 1, 2020, through June 30, 2020 (State Fiscal Year 2020). State Fiscal Year 2020 capitation rate ranges will be determined by the Department no later than October 1, 2019, or upon CMS approval, whichever is later. The MCO assumes risk for the cost of services covered under this Contract and will incur loss if the cost of furnishing the services exceeds the payments under the Contract. The MCO must accept as payment in full, the amount paid by the Department.

No payment will be made for services furnished by a provider other than the MCO provider, if the services were available under the provider Contract unless otherwise authorized by the MCO except when these [payments](#) are specifically required to be made by the [State](#) in Title XIX of the [Act](#), in [42 CFR chapter IV](#), or when the [State](#) agency makes direct [payments to network providers](#) for graduate medical education costs approved under the [State plan](#).

Payments for medical services provided for under the Contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS. CMS may deny payment for new enrollees to the State if its determination is not timely contested by the MCO per 42 CFR 438.726(b) and §438.730.

The Department is obligated to make payment either by mail or electronic transfer to the MCO. Capitation payments will be made for the month in which services are being provided according to the payment schedule for the month, as set forth in this Contract. The Department reserves the right to change the payment process, but the payment timing described above will remain the same.

Participant population (enrollee months) were developed based on historical FFS participation. SED waiver enrollee capitation amounts were based on other state experience, PRTF costs,

projected service utilization and other factors. The MCO will be paid a capitated rate on a PMPM rate set by the State, which shall be firm and fixed for the period of the contract, subject to any rate adjustments warranted for modifications to State or Federal regulation, waiver amendments, State Plan amendments, etc. In addition, the MCO, serving as an Administrative Service Organization (ASO), shall be paid a fixed monthly amount for ASO services related to socially necessary services (SNS) administration. This payment shall be issued by the Bureau for Children and Families.

#### **4.6 Federal Disallowance**

If the federal government recoups money from the State of West Virginia for expenses and/or costs that are deemed unallowable by the federal government, the Department has the right to, in turn, recoup payments made to the MCO for these same expenses and/or costs, even if they had not been previously disallowed by the Department and were incurred by the MCO. Any such expenses and/or costs would then be deemed unallowable by the Department. If the Department retroactively recoups money from the MCO due to a federal disallowance, the Department will recoup the entire amount paid to the MCO for the federally disallowed expenses and/or costs, not just the federal portion.

#### **4.7 Enrollee Eligibility Capitation Adjustments**

Changes in enrollee eligibility categories which become known subsequent to payment of a capitation payment will not relieve the MCO of liability for provision of care for the period for which capitation payment has been made.

The MCO must serve all enrollees for whom current payment has been made to the MCO without regard to disputes about enrollment status and without regard to any other identification requirements. If such person later is found to be inappropriately enrolled in the MCO, then the MCO will retain the capitation payment for that month and must provide services for that month. The Department will make every effort to ensure that only those individuals eligible for enrollment are enrolled in the MCO. In instances where enrollment is disputed between two (2) MCOs, the Department will be the final arbitrator of the MCO membership and reserves the right to recover an inappropriate capitation payment, including but not limited to untimely notice from the MCO to the Department of an enrollee's request to disenroll, when such requests are submitted to the MCO.

#### **4.8 Information**

The Department will notify the MCO in writing of any exclusion initiated by DHHR for a FFS Medicaid or BCF provider so that the MCO can exclude that provider from its network.

#### **4.9 Ongoing Managed Care Organization Monitoring**

To ensure the quality of care, the Department will undertake monitoring activities outlined in 42 CFR 438.66 including, but not limited to:

1. Analyze the MCO's access enhancement programs, financial and utilization data, and other reports to monitor the value the MCO is providing in return for the State's capitation revenues. Such efforts will include audits of the MCO and its Subcontractors.

2. Conduct regular enrollee surveys addressing issues such as satisfaction and reasons for disenrollment.
3. Review MCO certifications on a regular basis.
4. At DHHR's discretion, commission or conduct additional objective studies of the effectiveness of the MCO.
5. Monitor the enrollment and termination practices.
6. Assure the proper implementation of the required grievance procedures.
7. Conduct periodic reviews of the MCO provider credentialing process and network to ensure that providers excluded from Medicaid and BCF participation are excluded from the MCO provider network.

These monitoring activities will take place at least once per year. The state will also perform a readiness review at least three (3) months prior to implementing a managed care program or the addition of a new eligibility group. The Department or its contractors must provide to the MCO summaries, at the Department's expense, of all monitoring activity reports, surveys, audits, studies, reviews, and analyses.

The Department will submit to CMS a report on the managed care program no later than one hundred eighty (180) days after the end of each contract year and the report will be posted on the state's website and provided to the state's Medical Care Advisory Committee.

#### **4.10 Utilization Review and Control**

The MCO may place appropriate limits on the covered services provided under this Contract on the basis of criteria applied under the Medicaid or BCF State Plans, such as medical necessity or for the purpose of utilization control, provided the MCO services can reasonably be expected to achieve the purpose for which such services are furnished. The MCO must ensure that services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. The MCO is prohibited from arbitrarily denying or reducing the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. Notwithstanding the above, all covered services must be provided in compliance with the Mental Health Parity and Addiction Equity Act of 2008, and with EPSDT requirements and respective federal regulations.

The Department will have the authority to override any MCO utilization management guideline on a case-by-case basis. The DHHR Medical Director or BCF designee must coordinate with the MCO Medical Director in the event an override is appropriate based on thorough internal review. The MCO must be responsible for payment should a utilization management guideline be overridden.

#### **4.11 Force Majeure**

The MCO will be excused from performance hereunder for any period that it is prevented from providing, arranging for, or paying for services as a result of a catastrophic occurrence or natural disaster including but not limited to an act of war, and excluding labor disputes.

#### **4.12 Time Is of the Essence**

In consideration of the need to ensure uninterrupted and continuous MCO performance and service delivery, time is of the essence in the performance of the obligations under this Contract.

#### **4.13 MCO Response Time Frames**

The MCO must submit required reports, requests for information, documentation, ad hoc reports, data certification forms, overpayment remittances, or any other item required within the time frames provided by this Contract or by the Department. If an MCO does not submit a required or ad hoc report, requests for information, documentation, data certification form, overpayment remittance, or item required to meet any State or Federal reporting requirements (e.g., provider-preventable conditions) to the Department within the timeframes outlined in this Contract or in the Department's request, the Department may assess liquidated damages on the MCO. The MCO will have a one (1) business day grace period following the due date of the data, report, requests for information, documentation, overpayment remittance, or data certification form. However, for each additional calendar day an item is overdue beyond the grace period, the Department may assess liquidated damages on the MCO as outlined in Article II, Section 6 and Appendix F.

### **5. DECLARATIONS AND MISCELLANEOUS PROVISIONS**

#### **5.1 Competition Not Restricted**

In signing this Contract, the MCO asserts that no attempt has been made or can be made by the MCO to induce any other person or firm to submit or not to submit a proposal for the provision of services covered by this Agreement for the purpose of restricting competition.

#### **5.2 Binding Authority**

Each MCO representative signing the Contract must submit written certification along with the signed Contract that he/she is the person in the organization responsible for, or authorized to make, decisions regarding this Contract.

#### **5.3 Nonsegregated Facilities**

The MCO certifies that it does not and will not maintain or provide for its employees any segregated facilities at any of its establishments, and that it does not permit its employees to perform their services at any location, under its control, where segregated facilities are maintained. The MCO agrees that a breach of this certification is a violation of Equal Opportunity in Federal employment. In addition, the MCO must comply with the Federal Executive Order 11246 entitled "Equal Employment Opportunity" as amended by Executive Order 11375 and as supplemented in the United States Department of Labor Regulations (41 CFR Part 30). As used in this certification, the term "segregated facilities" includes any waiting rooms, restaurants and other eating areas, parking lots, drinking fountain, recreation or entertainment areas, transportation, and housing facilities provided for employees which are segregated on the basis of race, color, religion, or national origin, because of habit, local custom, national origin, or otherwise.

The organization further agrees (except where it has obtained identical certifications from proposed Subcontractors for specific time periods) that it will obtain identical certifications from

proposed Subcontractors which are not exempt from the provisions for Equal Employment Opportunity; that it will retain such certifications in its files; and that it will forward a copy of this clause to such proposed Subcontractors (except where the proposed Subcontractors have submitted identical certifications for specific time periods).

#### **5.4 Offer of Gratuities**

The MCO warrants that it has not employed any company or person other than a bona fide employee working solely for the MCO or a company regularly employed as its marketing agent to solicit or secure the Contract and that it has not paid or agreed to pay any company or person any fee, commission, percentage, brokerage fee, gifts, or any other consideration contingent upon or resulting from the award of the Contract.

For breach or violation of this warranty, the Department will have the right to terminate this Contract with a thirty (30) calendar day notice without liability or, at its discretion to pursue any other remedies available under this Contract or by law.

#### **5.5 Employment/Affirmative Action Clause**

The MCO agrees to supply employment/affirmative action information as required for agency compliance with Title VI and VII of the Civil Rights Acts of 1964.

#### **5.6 Hold Harmless**

The MCO agrees to indemnify, defend and hold harmless the State of West Virginia and the Department, its 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. The activities of the Fiscal Agent do not constitute the MCO's performance;
2. Any claims or losses to any person or firm injured or damaged by the erroneous or negligent acts, including without limitation, disregard of Federal or State Medicaid statutes or regulations of the MCO, its officers, employees, or Subcontractors in the performance of the contract;
3. Any claims or losses resulting to any person or entity injured or damaged by the MCO, 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;
4. Any failure of the MCO, its officers, employees, or Subcontractors to observe State and Federal laws, including but not limited to labor and minimum wage laws.

#### **5.7 Confidentiality**

The MCO agrees to comply with applicable state and federal law regarding confidentiality/privacy including the confidentiality requirements of §1160 and §1902(a)(7) of the Social Security Act; the information safeguarding requirements of Title 42, Part 431, Subpart F (42 CFR 431 F); Title 45, Parts 160, 162, and 164; and the Federal Information Security Management Act (FISMA), to the extent they apply.

The MCO agrees that all material and information, and particularly information relative to individual applicants or enrollees of assistance through the Department, provided to the MCO by the State or acquired by the MCO in performance of the Contract whether verbal, written, recorded magnetic media, cards or otherwise will be regarded as confidential information and all necessary steps must be taken by the MCO to safeguard the confidentiality of such material or information in conformance with federal and state statutes and regulations.

The MCO agrees not to release any information provided by the Department or providers or any information generated by the MCO regarding this Contract without the express consent of the Contracting Officer, except as otherwise provided in this Contract.

### **5.8 Independent Capacity**

The MCO, its officers, employees, Subcontractors, or any other agent of the MCO in performance of this Agreement must act in an independent capacity and must not hold themselves out to be officers or employees of the State of West Virginia or of the Department.

### **5.9 Contract Liaison**

Both parties agree to have specifically named Contract liaisons at all times. These representatives of the parties will be the first contacts regarding any questions and problems which arise during implementation and operation of the contract. Both parties agree to immediately notify the other party in writing should they appoint a Contract liaison other than the liaison named in this contract. The MCO's Contract liaison may also fulfill the duties of the Medicaid Administrator, as outlined in Article III, Section 5 of the contract.

### **5.10 Key Staff Positions**

Key MCO personnel (e.g., owners, directors) must meet state law requirements for experience, licensure, and other ownership requirements.

The MCO must provide the Department with an organizational chart depicting the key staff positions in the Medicaid line of business by October 1<sup>st</sup> of each Contract year. The organizational chart must include the names, titles, and contact information for the following key staff positions or functions:

- Contract Liaison/Medicaid Administrator,
- Chief Executive Officer (CEO),
- Chief Financial Officer (CFO),
- Medical Director,
- Medical Management (Utilization Review) Director,
- Care Management Director,
- Behavioral Health Medical Director,
- Dental Director,
- Social Services Director,
- SNS Liaison,
- Quality Director,
- Enrollee Services Director,
- Claims Payment Director,

- Network Development Director,
- Provider Relations Director,
- Program Integrity Lead,
- Information Technology Director,
- Community Engagement Director, and
- Medicaid Enrollee Advocate.

The MCO must notify the Department in writing of changes in key staff positions when individuals either leave or fill these key positions within fourteen (14) calendar days of any change. The MCO must also provide an updated organizational chart within fourteen (14) calendar days of request.

All key staff or his or her designee must respond to requests of the Department within three (3) business days.

### **5.11 Location of Operations**

The MCO is required to have a physical presence in West Virginia, including: ensuring at least eighty (80) percent of its total full-time equivalent positions allocated to manage care individuals covered under this contract have a primary work place in the state of West Virginia and the operation of call center services is in a West Virginia location. The MCO must notify the Department forty-five (45) calendar days in advance of any proposal to modify claims operations and processing, enrollee services, or case management processes that may include the relocation of operations. The MCO must be responsible for any costs incurred by other contracted vendors of the Department for required updates needed as a result of such change.

### **5.12 Communication with the Department**

The MCO must acknowledge receipt of the Department's written, electronic, or telephonic information requests as expeditiously as the matter requires or no later than two (2) business days after receipt of the request from the Department. The MCO's information request acknowledgment must include a planned date of information request resolution. A detailed resolution summary advising the Department of the MCO's action and resolution must be rendered to the Department in the format requested.

The Department's urgent information requests such as issues involving legislative inquiries, inquiries from other governmental bodies, or urgent inquiries as determined by the Department, must be given priority by the MCO and completed in accordance with the information request or instructions from the Department. The Department will provide guidance with respect to any necessary deadlines or other requirements. A resolution summary, as described by the Department, must be submitted to the Department.

MCO's failure to communicate complete, meaningful, and timely responses to all Department's information requests may result in remedies as described in Article II, Section 6 and Appendix F of this contract.

### **5.13 Waivers**

No covenant, condition, duty or obligation, or undertaking contained in or made a part of this Contract will be waived except by the written agreement of the parties.

### **5.14 Compliance with Applicable Laws, Rules, And Policies**

The MCO and its Subcontractors, in performing this contract, must comply with all applicable Federal and State laws, regulations, and written policies, including those pertaining to licensing and including those affecting the rights of enrollees. MCOs must include provisions relating to compliance with such laws in Subcontracts with providers. Assessment of compliance must be included in the MCOs' credentialing procedures to the extent feasible.

Work performed under this Contract must conform to the federal requirements set forth in Title 45, CFR Part 74 and Title 42, Part 434. The MCO must also abide by all applicable Federal and State laws and regulations including but not limited to:

- Chapter 9, Article 5 and Chapter 49, Articles 1, 2, and 4 of the West Virginia Code pertaining to the state's foster care program and transitioning the foster care population to an MCO (2019 WV House Bill 2010);
- Section 504 of the Rehabilitation Act of 1973;
- Title IX of the Education Amendments of 1972;
- The Age Discrimination Act of 1975;
- Titles II and III of the Americans with Disabilities Act;
- Section 542 of the Public Health Service Act, pertaining to nondiscrimination against substance users;
- Title 45, Part 46 of the Code of Federal Regulations, pertaining to research involving human subjects;
- Title 45 Parts 160 and 164 Subparts A and E and Part 162, pertaining to privacy and confidentiality;
- Title 42 Parts 434 and 438 of the Code of Federal Regulations, pertaining to managed care;
- Title 42 Parts 438, 440, and 457 of the Code of Federal Regulations, pertaining to mental health parity and addiction equity;
- Copeland Anti-Kickback Act;
- Davis-Bacon Act;
- Contract Work Hours and Safety Standards;
- Right to Inventions Made Under a Contract or Agreement;
- Clean Air Act and Federal Water Pollution Control Act;
- Byrd Anti-Lobbying Amendment;
- Debarment and Suspension;

- American Disabilities Act of 1990 as amended;
- Assisted Suicide Funding Restriction Act of 1997;
- Patient Protection and Affordable Care Act (PPACA);
- Mental Health Parity and Addiction Equity Act of 2008;
- Family First Prevention Services Act (FFPSA) of 2018;
- Health Care and Education Reconciliation Act of 2010 (HCERA);
- Federal Information Security Management Act (FISMA); and
- Any other pertinent Federal, State or local laws, regulations, or policies in the performance of this contract.

The MCO must comply with all applicable Federal and State laws, regulations, policies, or reporting requirements needed to comply with the policies and regulations set forth in the PPACA, P.L. 111-148, enacted on March 23, 2010, and the Health Care and Education Reconciliation Act of 2010 (HCERA), P.L. 111-152, enacted on March 30, 2010.

The MCO must also comply with requirements and regulations pertaining to:

- Copyrights, data, and reporting and patent rights under any Contract involving research, developmental, experimental, or demonstration work with respect to any discovery or invention which arises or is developed in the course of this contract;
- Applicable standards, orders or requirements under Section 306 of the Clean Air Act (42 USC 1857(h)), section 508 of the Clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR part 15); and
- Energy efficiency which are contained in the State energy conservation plan issued in compliance with the Energy Policy and Conservation Act (P.L. 94-165).

The MCO must procure all necessary permits and licenses and abide by all applicable laws, regulations, and ordinances of the United States, State of West Virginia, and political subdivision in which work under the Contract is performed.

The MCO must retain at all times during the period of this Contract a valid Certificate of Authority issued by the State Commissioner of Insurance.

The MCO must pay any sales tax, use and personal property taxes arising out of this Contract and the transactions contemplated thereby. Any other taxes levied upon this contract, the transaction, or the equipment or services delivered pursuant hereto will be borne by the MCO.

The MCO must adhere to the provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA) Public Law 100-578.

### **5.15 Non-discrimination**

The MCO must comply with all Federal and State laws relating to non-discrimination, including but not limited to : Title VI of the Civil Rights Act of 1964, (42 U.S.C. §2000d et seq.) and as applicable 45 CFR Part 80 or 7 CFR Part 15; Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794); Americans with Disabilities Act of 1990 (42 U.S.C. §12101 et seq.); Age Discrimination Act of 1975 (42 U.S.C. §§6101-6107); Title IX of the Education Amendments of 1972 (20 U.S.C. §§1681-1688); Food Stamp Act of 1977 (7 U.S.C. §200 et seq.); Executive Order 11246 and its implementing regulations at 41 CFR Part 60; Executive Order 13279, and its implementing regulations at 45 CFR Part 87 or 7 CFR Part 16; The Immigration Reform and Control Act of 1986 (8 U.S.C. §1101 et seq.). The MCO may not discriminate in enrollment, delivery of health care, or any other activity against enrollees on the basis of health status, conditions of or type of enrollment in the geographic areas within the managed care initiative, or need for health care services.

The Department will deny payments for any new enrollees for whom payment is denied by CMS due to the MCO's discrimination of enrollees based on their health status or services sought.

### **5.16 Federal Requirements and Assurances**

The MCO must comply with those federal requirements and assurances for enrollees of federal grants provided in OMB Standard Form 424B which are applicable to the MCO. The MCO is responsible for determining which requirements and assurances are applicable to the MCO. Copies of the form are available from the Department.

The MCO must provide for the compliance of any Subcontractors with applicable federal requirements and assurances.

### **5.17 Lobbying**

The MCO, as provided by 31 U.S.C. 1352 and 45 CFR 93.100 et seq., will not pay federally appropriated funds to any person for influencing or attempting to influence an officer or employee of any agency, a member of the U.S. Congress, an officer or employee of the U.S. Congress, or an employee of a member of the U.S. Congress in connection with the awarding of any federal contract, the making of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

The MCO must submit to the Department a disclosure form as provided in 45 CFR 93.110, if any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of the U.S. Congress, an officer or employee of the U.S. Congress, or an employee of a member of the U.S. Congress in connection with this contract.

The MCO must require that the language of this certification be included in the award documents for all sub-awards at all tiers (including Subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients must certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this Contract was made and entered into. Submission of this certification is a prerequisite for making and entering into this Contract imposed under Section 1352, Title 31, US Code. Any person who fails to file the required certification will be subject to a civil penalty.

#### **5.18 Disclosure of Interlocking Relationships**

If the MCO is not also a Federally-Qualified MCO under the Public Health Service Act, it must report to the State, and on request, to the Secretary, the Inspector General of DHHS, and the Comptroller General, a description of transactions between the MCO and parties in interest. Transactions that must be reported include: (1) any sale, exchange, or leasing of property; (2) any furnishing for consideration of goods, services, or facilities (but not salaries paid to employees); and (3) any loans or extensions of credit. The MCO must make the information reported available to its enrollees upon reasonable request.

The MCO will covenant that it, its officers or enrollees, employees, or Subcontractors will not acquire any interest, direct or indirect which would conflict or compromise in any manner or degree with the performance of its services hereunder. The MCO further covenants that in the performance of the contract, the MCO must periodically inquire of its officers, enrollees, and employees concerning such interests. Any such interests discovered must be promptly presented in detail to the Department.

#### **5.19 Department's Data Files**

The Department's data files and data contained therein will be and remain the Department's property and must be returned to the Department by the MCO upon the termination of this Contract at the Department's request, except that any Department data files no longer required by the MCO to render services under this Contract must be returned upon such determination at the Department's request.

The Department's data will not be utilized by the MCO for any purpose other than that of rendering services to the Department under this contract, nor will the Department's data or any part thereof be disclosed, sold, assigned, leased, or otherwise disposed of to third parties by the MCO unless there has been prior written Department approval.

The Department must, upon request to the MCO, have the right of access and use of any data files retained or created by the MCO for systems operation under this contract.

The MCO must establish and maintain at all times reasonable safeguards against the destruction, loss, or alteration of the Department's data and any other data in the possession of the MCO necessary to the performance of operations under this contract.

#### **5.20 Changes Due to a Section 1915(b) Freedom of Choice or 1115 Demonstration Waiver**

The conditions described in the contract, including, but not limited to enrollment and the right to disenrollment, are subject to change as provided in any waiver under section 1915(b) or 1115 of the Social Security Act (as amended) obtained by the Department.

### **5.21 Contracting Conflict of Interest Safeguards**

The MCO asserts that to the best of its knowledge that the process of procuring this Contract has been compliant with the federal contracting requirements set forth in 41 U.S.C. 423 and 42 CFR 438.3.

The MCO must not pay, offer to pay, or agree to pay, either directly or indirectly, any fee, commission, compensation, gift, gratuity, or other thing of value to an employee or agent of the State of West Virginia with the intent to influence work related to the Contract.

### **5.22 Prohibition Against Performance Outside the United States**

The MCO and a Subcontractor must comply with the requirements of Section 6505 of the PPACA, entitled “Prohibition on Payments to Institutions or Entities Located Outside of the United States.”

All work performed by the MCO or a Subcontractor under this Contract must be performed exclusively within the United States. No payments must be made for services or items by the MCO or a Subcontractor to any entity or financial institution outside of the United States.

All information obtained by the MCO or a Subcontractor under this Contract must be stored and maintained within the United States.

The term “within the United States” means any location inside the territorial boundaries comprising the United States of America, including of any of the forty-eight (48) coterminous states in North America, the states of Alaska and Hawaii, and the District of Columbia.

### **5.23 Freedom of Information**

Due regard will be given for the protection of proprietary information contained in all procurement-related documents received; however, the MCO should be aware that all materials associated with this agreement are subject to the terms of the Freedom of Information Act (FOIA), the Privacy Act and all rules, regulations, and interpretations resulting therefrom. It will not be sufficient for the MCO to merely state generally that the material is proprietary in nature and not therefore subject to release to third parties. Those particular pages of sections which MCO applicant believes to be proprietary must be specifically identified as such.

## **6. CONTRACT REMEDIES AND DISPUTES**

### **6.1 MCO Performance**

The MCO is expected to meet or exceed all the Department’s objectives and standards, as set forth in the Contract. All areas of responsibility and all Contract requirements will be subject to performance evaluation by the Department. A designated representative of the MCO and a designated representative of the Department may meet as requested by either party, to review the performance of the MCO under this Contract. Written minutes of such meetings will be kept. In the event of any disagreement regarding the performance of services by the MCO under this Contract, the designated representatives must discuss the performance problem and negotiate in good faith in an effort to resolve the disagreement.

For purposes of this Contract, an item of non-compliance/non-performance means a specific action of the MCO or its Subcontractor, agent and/or consultant that:

- Violates a provision of this Contract including Appendices;
- Fails to meet an agreed measure of performance and/or standard; or
- Represents a failure of the MCO to be reasonably responsive to a reasonable request of the Department for information, assistance, or support within the timeframe specified by the Department.

Non-performance of this Contract includes, but is not limited to:

- Failing substantially to provide Medically Necessary covered services that the MCO is required to provide, under law or under its Contract with the Department, to an enrollee covered under the Contract;
- Failing substantially to provide covered SNS that the MCO is required to provide, under law or under its Contract with the Department, to an enrollee covered under the Contract;
- Imposing premiums, copays, or charges that are in excess of the premiums, copays, or charges permitted under the Medicaid program;
- Acting to discriminate among enrollees on the basis of their health status or need for health care services, including terminating of enrollment or refusal to reenroll an individual, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by individuals whose medical condition or history indicates probable need for substantial future medical services;
- Misrepresenting or falsifying information that the MCO furnishes to CMS, ACF, or to the State;
- Misrepresenting or falsifying of information that the MCO furnishes to an enrollee, potential enrollee, health care provider or SNS provider;
- Distributing directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information;
- Failing to maintain an adequate network of properly credentialed providers;
- Failing to comply with the provider reimbursement requirements of this Contract;
- Failing to comply with the reporting requirements of this Contract;
- A pattern of inappropriately denying payments for emergency-related services; or
- Violating the requirements of sections 1903(m) or 1932 of the Social Security Act, and any implementing regulations.

## **6.2 Corrective Action Plan (CAP)**

At its option, the Department may require the MCO to submit to the Department or its designee a written plan (the “Corrective Action Plan (CAP)”) to correct or resolve non-performance of the Contract, as determined by the Department.

1. The CAP must provide:
  - a. A detailed explanation of the reasons for the MCO’s non-performance;
  - b. The MCO’s assessment or analysis of the cause, if applicable; and
  - c. A specific proposal to cure or resolve the non-performance.
2. The Department may require a CAP to provide:
  - a. Accelerated monitoring that includes more frequent or more extensive monitoring by the Department or its agent, including accelerated monitoring of any area in which the compliance is not fully met;
  - b. Additional, more detailed, financial, and/or programmatic reports to be submitted by the MCO; and
  - c. Additional and/or more detailed financial and/or programmatic audits or other reviews of the MCO.
3. The CAP must be submitted by the deadline set forth in the Department’s request for a CAP. The CAP is subject to approval by the Department, which will not be unreasonably withheld.
4. The Department will notify the MCO in writing of its final disposition of the Department’s concerns. If the Department accepts the MCO’s proposed CAP, the Department may:
  - a. Condition such approval on completion of tasks in the order or priority that the Department may reasonably prescribe;
  - b. Disapprove portions of the MCO’s proposed CAP;
  - c. Require additional or different corrective action(s), not limited to the actions described in paragraph (2); or
  - d. Notwithstanding the submission and acceptance of a CAP, MCO remains responsible for achieving all written performance criteria.
5. The Department’s acceptance of a CAP under this Section will not:
  - a. Excuse the MCO’s prior non-performance;
  - b. Relieve the MCO of its duty to comply with performance standards; or
  - c. Prohibit the Department from assessing additional Contract remedies or pursuing other appropriate remedies for continued non-performance.

The Department retains authority to impose additional remedies under this Contract or state and federal statutes that address areas of non-performance. Nothing in this provision prevents the Department from exercising that authority.

### 6.3 Conditions Endangering Performance

At its option, the Department may provide the MCO with written notice of conditions endangering Contract performance. Conditions that endanger performance include, but are not limited to, the following:

- Failing to substantially provide Medically Necessary covered items and services that are required (under law or under the MCO's Contract with the Department) to be provided to an enrollee covered under the Contract;
- Failing to substantially provide covered SNS that are required (under law or under the MCO's Contract with the Department) to an enrollee covered under the Contract;
- Imposing premiums, copays, or charges enrollees in excess of the premiums, copays, or charges permitted under the Medicaid program;
- Engaging in any practice that discriminates on the basis of health status or need for health care services;
- Misrepresenting or falsifying information furnished to the Department, an enrollee, a potential enrollee, or health care provider;
- Failing to comply with the physician incentive requirements under section 1903(m)(2)(A)(x) of the Social Security Act; or
- Distributing directly or through any agent or independent contractor marketing materials that contain false or misleading information.

The Department must notify the CMS Regional Office and ACF at any time any of the above conditions are found to exist or as appropriate at any time the MCO:

- Is found to have performance deficiencies in any of the above areas;
- Is under a CAP;
- Has been assessed liquidated damages;
- Has had enrollment suspended;
- Has had temporary management appointed by the State;
- Has had payments suspended;
- Is engaged in dispute resolution;
- Is being terminated for default; or
- Is otherwise non-compliant or has a performance deficit as described in Article II, Section 6 of this contract.

Unless otherwise specified in the written notice of condition(s) that endanger performance, the Department, in its sole discretion, may allow the MCO an allotted amount of business days to remedy the condition(s) contained in the notice. If after such notice of conditions that endanger performance the MCO fails to remedy the conditions contained in the notice, within ten (10)

business days or the time period specified in the notice, the Department may pursue other remedies under this Contract or any intermediate remedies outlined in 42 CFR 438.702.

#### **6.4 Failure to Meet Contract Requirements**

The MCO must comply with all requirements and performance standards set forth in this Contract. The MCO agrees that failure to comply with all provisions of the Contract may result in the assessment of remedies and/or termination of the Contract, in whole or in part, in accordance with this Article. The MCO agrees and understands that the Department may pursue contractual remedies for non-performance under the Contract. At any time and at its discretion, the Department may impose or pursue one or more remedies for each item of non-performance and will determine remedies on a case-by-case basis.

The Department is entitled to monetary damages in the form of actual, consequential, direct, indirect, special, and/or Liquidated Damages resulting from the MCO's non-performance under this Contract. In some cases, the actual damage to the Department as a result of the MCO's failure to meet any aspect of the responsibilities of the Contract and/or to meet specific performance standards set forth in the Contract will be difficult or impossible to determine with precise accuracy. Therefore, in the event of non-performance under this Contract, the Department will impose, in writing, Liquidated Damages against the MCO. The Department will assess Liquidated Damages regardless of whether the non-performance is the fault of the MCO or the MCO's Subcontractors, agents and/or consultants, provided the Department has not materially caused or contributed to the non-performance. The Department will provide 15 days' notice of its intent to assess Liquidated Damages against the MCO. The MCO will have 10 days from receipt of the Letter of Intent to assess Liquidated Damages to appeal the sanction.

The Liquidated Damages prescribed in this Contract are not intended to be in the nature of a penalty, but are intended to be reasonable estimates of the Department's projected financial loss and damage resulting from the MCO's non-performance. Accordingly, in the event the MCO fails to perform in accordance with the Contract, the Department may assess Liquidated Damages as provided in this Section and in Appendix F of this Contract. Monetary penalties imposed under this Contract will not exceed the amounts established under 42 CFR §438.704.

Any Liquidated Damages assessed by the Department will be due and payable within thirty (30) calendar days after the MCO's receipt of the notice of damages, regardless of any dispute in the amount or interpretation which led to the notice, or an appeal of the notice filed by the MCO. If MCO fails to pay assessed damages within thirty (30) calendar days, the amount of damages will be deducted against capitation payments due to the MCO or that become due at any time after assessment of the Liquidated Damages. The Department will make deductions until the full amount payable by the MCO is collected. All Liquidated Damages imposed pursuant to this Contract, whether paid or due, must be paid by the MCO out of administrative costs and profits.

Per 42 CFR 438.704(c), if the Department imposes Liquidated Damages on the MCO for charging premiums or charges in excess of the amounts permitted under the Contract, the Department will deduct the amount of the overcharge from the Liquidated Damage and return it to the affected enrollee.

If at any time the Department determines the MCO has not met any aspect of the responsibilities of the Contract and/or the specific performance standards due to mitigating circumstances, the Department reserves the right to waive all or part of the Liquidated Damages. All such waivers must be in writing, contain the reasons for the waiver, and be signed by the representative of the Department.

Neither the occurrence of an event constituting an alleged MCO non-performance of this Contract nor the pending status of any claim for non-performance of Contract is grounds for the suspension of performance, in whole or in part, by the MCO of any duty or obligation with respect to the performance of this Contract.

The MCO is responsible for any damages, penalties, or disallowances imposed on the State or MCO arising from any non-compliance or non-performance related to the delivery of the covered services or deliverables under this Contract by the MCO, its Subcontractors or agents.

### **6.5 Temporary Management**

The State must appoint temporary management as a remedy under the circumstances described in 42 CFR 438.706 and 42 CFR 438.704, if the State determines that the MCO has repeatedly failed to meet the substantive requirements in Sections 1903(m) or 1932 of the Social Security Act and that the continued operation of the MCO would be hazardous to enrollees. The Commissioner of the Offices of the Insurance Commissioner will be responsible for the imposition of such remedy as set forth in Section 33-25A-19 of the West Virginia HMO Act of 1977. If temporary management is imposed, the State will notify enrollees of their right to terminate enrollment in the MCO.

The State may terminate the Contract and provide their enrollees' Medicaid and SNS benefits through other options included in the applicable State Plans or waivers.

Nothing precludes the Department's right to appoint temporary management during the time in which the MCO is remedying the condition(s) or while an appeal requested by the MCO is pending. However, before any temporary management is appointed, the Department will notify, in writing, the MCO of the specific non-performance. Within ten (10) business days of receipt of this written notification, the MCO will forward a plan to remedy this non-performance to the Department. The Department will, as soon as possible, notify the MCO whether it agrees to the plan, and if so, the MCO will immediately begin to remedy the non-performance in accordance with the plan, and will have fifteen (15) business days to do so. If the plan is not accepted, such reasons will be given, and the MCO will revise the plan to reflect the Department's changes, and then will resubmit and then will immediately begin to remedy the non-performance and will have fifteen (15) business days to do so.

### **6.6 Suspension of New Enrollment**

Whenever the Department determines non-performance by the MCO under this Contract, the Department may suspend enrollment of new enrollees into the MCO under this Contract. The Department, when exercising this option, must notify the MCO in writing of its intent to suspend new enrollment at least ten (10) business days prior to the beginning of the suspension period in accordance with Article II, Section 6.8. The suspension period may be for any length of time specified by the Department, or until the non-performance is remedied, or for an unspecified

time period. The suspension period may extend up to the Contract expiration date as provided under Article I. The Department may grant MCO enrollees the right to terminate enrollment without cause and to notify the affected enrollees of their right to disenroll and to re-enroll in another MCO.

### **6.7 Payment Suspension**

The Department may suspend portions of capitation payments from the MCO as a remedy for non-performance. Whenever the Department determines that the MCO has failed to provide one (1) or more of the covered Contract services, the Department may suspend an estimated portion of the MCO's capitation payment in subsequent months. Such suspension amount will be equal to the amount of money the Department expected the MCO to pay for covered Contract services, plus any administrative costs involved. The MCO may not deny any covered Contract services in order to receive adjusted payment levels. The MCO will be given written notice at least ten (10) business days prior to the suspension of any capitation payment in accordance with Article II, Section 6.8.

When it suspends payments under this section, the Department must submit to the MCO a list of the enrollees for whom payment is being suspended, the nature of service(s) denied, and payments the Department must make to provide covered Contract services. When all payments have been made by the Department for the MCO covered Contract services, the Department will reconcile the estimated suspension against actual enrollee payments.

The Department may suspend MCO payments in accordance with 42 CFR 455.23 in case of a credible allegation of fraud against the MCO.

### **6.8 Dispute Resolution**

This Contract is not subject to arbitration. Any action concerning MCO non-performance under this Contract will be decided in accordance with Article II, Section 6 of this Contract by the Contracting Officer who will put his/her decision in writing and serve a copy on the MCO and Department as soon as administratively possible after the MCO non-performance was identified. The Contracting Officer's decision will be final unless within ten (10) business days of the receipt of such copy, the MCO or Department files with the Contracting Officer a written appeal.

As a response to an appeal, the Contracting Officer must issue his/her recommended course of action to the Commissioner for either the BMS or BCF. The Commissioner will review the Contracting Officer's recommendation and issue a decision on the appeal within ten (10) business days.

Should the MCO disagree with the decision, the MCO can request a hearing before an administrative law judge within ten (10) business days, who will take evidence and hear oral argument. In connection with any appeal proceeding under this subsection, the MCO will be afforded an opportunity to be heard and to offer evidence and oral argument in support of its appeal. At such hearing, the Department will also offer evidence and oral argument in support of its position.

The administrative law judge, who will serve as an impartial fact finder, will issue a proposed decision to the MCO and to the Department within sixty (60) calendar days of the end of the

hearing. The MCO and/or the Department will have ten (10) business days after the mailing of the proposed decision to request a decision review. If such a request is made, the Secretary, DHHR will, thereafter, issue a final decision. There must be no ex parte communications with the administrative law judge during pendency of the appeal. During any appeal process, the copies of all pleadings or other documents being filed in connection with the appeal must be delivered to the administrative law judge. The reasonable costs of an administrative appeal including costs of reporting and preparing a transcript will be paid by the party appealing. Such decision will be final except to the extent that the MCO appeals to the Circuit Court of West Virginia. The pendency of an appeal to the Secretary or the Circuit Court will not automatically stay any notice of termination which may be appealable.

Pending final determination of any dispute, the MCO must proceed diligently with the performance of this Contract and in accordance with the Contracting Officer's direction.

The MCO's failure to follow the procedure set out above will be deemed a waiver of any claim which the MCO might have had.

The Department and the MCO agree that a State or Federal statute, rule, regulation, or Federal guideline will prevail over the provisions of this Section unless the statute, rule, regulation, or guidelines can be read together with this Section to give effect to both.

#### **6.9 Termination For Default**

The State of West Virginia, Department of Administration Purchasing and/or the Department may terminate performance of work under this Contract in whole, or in part, whenever the MCO defaults in performance of this Contract and fails to cure such default or make progress satisfactory to the Department toward Contract performance within a period of thirty (30) calendar days after receipt of notice of default (or such longer period as the Department may allow). Such termination will be referred to herein as "Termination for Default."

Events constituting a Termination for Default include, but are not limited to:

1. MCO insolvency or the MCO's failure to meet its financial obligations as they become due;
2. MCO failure to pay claims;
3. Untimely service authorizations or other acts or omissions of the MCO or its Subcontractors resulting in a substantial risk to the health of the enrollees;
4. The MCO or its Subcontractors, affiliates or agents are expelled or suspended from federal health insurance programs under Title XVIII or Title XIX of the Social Security Act;
5. Any action taken by the West Virginia Offices of the Insurance Commissioner deemed by DHHR to adversely affect the ability of the MCO to provide healthcare services to its enrollees;

6. Failure of the MCO to obtain signed provider agreements, Subcontractor agreements or agreements with other agents of the MCO that impairs the ability of the MCO to perform the services under the Contract and failure to cure within thirty (30) calendar days or such longer period as the Department may allow;
7. The MCO misrepresents, omits or otherwise falsifies information or the MCO knowingly permits its Subcontractors, affiliates or agents to provide fraudulent, intentionally misleading or misrepresentative information; or
8. Breach of any covenant contained in the Contract and failure to cure such covenant default within thirty (30) calendar days or such longer period as the Department may allow.

If the MCO defaults in the performance of the duties under the Contract, the Department may exercise remedies including, but not limited to:

1. Suspension of enrollment;
2. Suspension of capitation payments;
3. Appointment of a management company to oversee the operations of the MCO;
4. Imposition of civil and monetary penalties;
5. Pursuit of any other remedy permitted by law; or
6. Termination of the Contract.

Before terminating the contract, the State will provide the MCO with a pre-termination hearing.

The State will provide the MCO with written notice of its intent to terminate, the reason for termination, and the time and place of any hearing. If after notice of termination of the Contract for default, it is determined by the State or a court that the MCO was not in default or that the MCO's failure to perform or make progress in performance was due to causes beyond control and without the error or negligence of the MCO, or any Subcontractor, the notice of termination will be deemed to have been issued as a termination for the convenience of the Department, and the rights and obligations of the parties will be governed accordingly.

In the event the State of West Virginia, Department of Administration Purchasing and/or the Department terminates the Contract in full or in part as provided in this clause, the State of West Virginia, Department of Administration Purchasing may procure services similar to those terminated, and the MCO will be liable for any excess costs for such similar services for any calendar month for which the MCO has been paid to provide services to Medicaid clients.

Prior to the termination for default of the MCO, the Department may take the following steps:

- After a hearing before the administrative law judge, if one is requested by the MCO as set forth in Article II, Section 6.8, provide the MCO with written notice of the decision affirming or reversing the proposed termination of the contract, and the effective date of the termination, if applicable; and

- For an affirming decision, give enrollees of the MCO notice of the termination, and information regarding enrollees' options for receiving covered services following the termination, and the right to terminate enrollment in the MCO immediately without cause.

In the event of a termination for default, the MCO must be paid for those services which the MCO has provided.

The MCO may terminate performance of work under this Contract in whole, or in part, with written notification to the State of West Virginia, Department of Administration Purchasing through the Department, whenever the Department fails to make payment for services under this Contract for sixty (60) calendar days and fails to cure such non-payment or make progress toward curing nonpayment within a period of thirty (30) calendar days after receipt of the MCO's written notice of termination.

The rights and remedies of the Department provided in this clause are not exclusive and are in addition to any other rights and remedies provided by law or under this contract.

If the State of West Virginia, Department of Administration Purchasing through the Department terminates the Contract for default, the MCO will be responsible for all reasonable costs incurred by the Department, the State of West Virginia, or any of its administrative agencies to replace the MCO. These costs include, but are not limited to, the costs of procuring a substitute vendor and the cost of any claim or litigation that is reasonably attributable to the MCO's failure to perform any service in accordance with the terms of the Contract.

#### **6.10 Termination for Convenience**

The State of West Virginia, Department of Administration Purchasing through the Department or the MCO may terminate this Contract at any time with at least a thirty (30) calendar day written notice. The effective date must be the first day of a month. The MCO must be paid the following:

1. At the Contract price(s) for services delivered to and accepted by the Department.
2. At a price mutually agreed to by the MCO and the Department for services partially completed.

#### **6.11 Termination Due to Change in Law, Interpretation of Law, or Binding Court Decision**

Any change in Federal or State law, or any interpretation of law by the United States Department of Health and Human Services or by a court whose decisions constitute binding precedent in West Virginia, which significantly alters the MCO's required activities or any change in the availability of funds, will be viewed as binding and will warrant good faith renegotiation of the provisions of the Contract that are thus affected. If such renegotiation proves unsuccessful, the Contract may be terminated on written notice of either party to the other party at least thirty (30) calendar days prior to termination.

## **6.12 Termination for Managed Care Organization Bankruptcy**

In the event of the filing of a petition in bankruptcy by or against the MCO, the State of West Virginia, Department of Administration Purchasing through the Department will have the right to terminate the Contract upon the same terms and conditions as a Termination for Default.

## **6.13 Termination for Unavailability of Funds**

The State of West Virginia, Department of Administration Purchasing through the Department at its discretion, may terminate at any time, the whole, or any part of, this Contract or modify the terms of the Contract if federal or state funding for the Contract, the Medicaid program, or the Foster Care program as a whole is reduced or terminated for any reason. Modification of the Contract includes, but is not limited to, reduction of the rates or amounts of consideration, reducing services covered by the MCO, or the alteration of the manner of the performance in order to reduce expenditures under the contract. Whenever possible, the MCO will be given thirty (30) calendar days notification of termination.

After modification of the contract, the MCO will have the right not to continue the Contract if the new Contract terms are deemed to be insufficient, notwithstanding any other provision of this contract. The MCO will have a minimum of sixty (60) calendar days to notify the State of West Virginia, Department of Administration Purchasing through the Department regarding its desire to accept new terms. If the new capitation rates and any other Contract modifications are not established at least sixty (60) calendar days prior to the expiration of the initial or extension agreement, the Department will reimburse the MCO at the higher of the new or current capitation rates for that period during which the new agreement period had commenced and the MCO's sixty (60) calendar day determination and notification period had not been completed, and the MCO will be held to the terms of the executed contract.

If the Department is not allotted funds in any succeeding fiscal year for the continued use of the services covered by this contract, the Department may terminate the Contract pursuant to Article II, Section 6, hereof at the end of the affected current fiscal period without further charge or penalty. The Department is obligated to pay all charges incurred through the end of the fiscal year at which time this Contract will terminate. The Department must give the MCO written notice of such non-allocation of funds as soon as possible after the Department receives notice of such non-allocation. No penalty may accrue to the MCO in the event this provision is exercised.

## **6.14 Termination Obligations of Contracting Parties**

Upon Contract termination, the MCO and Subcontractors must allow the Department, its agents and representatives full access to the MCO's and Subcontractor facilities and records to arrange the orderly transfer of the contracted activities. These records include the information necessary for the reimbursement of any outstanding Medicaid or SNS claims.

Upon the date of notification of its intent to terminate the Contract, the MCO may no longer accept new enrollees. The MCO will remain responsible for providing services, including coverage of inpatient services, through the effective date of the Contract termination, to individuals enrolled with the MCO on or before the date of notification to DHHR. The MCO must provide DHHR with the names, PCP assignments, and primary diagnosis of all enrollees with care needs that require DHHR pre-authorization, those currently receiving case

management, and those with known future service needs (e.g. scheduled ambulatory surgery, pregnancy) by such date as determined by DHHR, with weekly updates thereafter. The MCO must provide DHHR with the names and treatment plans of enrollees with such plans.

Upon Contract termination, the MCO and Subcontractors must provide DHHR with all required reports and data through the end of the Contract period as described in this Contract. This requirement includes encounter data, which must be submitted no later than ninety (90) calendar days after the end of the quarter in which the encounters occurred. The Department may request an interim encounter data submission ninety (90) calendar days after the termination of the contract.

Where this Contract is terminated due to default by the MCO:

- The Department will be responsible for notifying all enrollees of the date of termination and process by which the enrollees will continue to receive services; and
- The MCO will be responsible for all reasonable expenses related to said notification.

Where this Contract is terminated for any reason other than default by the MCO:

- The Department will be responsible for notifying all enrollees of the date of termination and process by which the enrollees will continue to receive services; and
- The Department will be responsible for all expenses relating to said notification.

### **6.15 MCO Operations Transition**

MCO transition is defined as the activities that the MCO is required to perform upon termination or expiration of the Contract in situations where the MCO will transition data and documentation to the Department or a subsequent contractor. For purposes of this provision, "documentation" means all operational, technical, and user manuals used in conjunction with the software, services, and deliverables, in whole or in part, that the Department determines are necessary to view and extract application data in a proper format.

The MCO must provide the documentation in the formats in which the documentation exists at the expiration or termination of the Contract. The data, documentation, information, and services provided as detailed in this section must be provided at no additional cost to the Department or a subsequent contractor. The Department or subsequent contractor must receive and verify all relevant data, documentation and information. If the Department determines that the data, documentation or information is not accurate, complete, or HIPAA-compliant, the Department reserves the right to hire an independent contractor to assist the Department in obtaining and transferring all the required data and information, and to ensure that all of the data is HIPAA-compliant. The MCO is responsible for the reasonable cost of providing these services.

The MCO must maintain a Transition Plan covering the turnover of the program records and information maintained to either the Department or a subsequent contractor. The Transition Plan must be a comprehensive document detailing the proposed schedule, activities, information and

resource requirements associated with the turnover tasks. The Department reserves the right to review the MCO Transition Plan and any significant modifications to the previously approved Transition Plans. The Department reserves the right to provide CMS and ACF as appropriate with Transition Plan documentation upon request.

The MCO must transfer to the Department or a subsequent contractor all data and information necessary to transition operations, including: data and reference tables; data entry software; third-party software and modifications; documentation relating to software and interfaces; functional business process flows; and operational information, including correspondence, documentation of ongoing or outstanding issues, operations support documentation, and operational information regarding Subcontractors. In addition, the MCO must provide the following to the Department or a subsequent contractor:

- The MCO must provide data, information, and services necessary and sufficient to enable the Department to map all MCO data from the MCO's system(s) to the replacement system(s) of Department or a successor contractor, including a comprehensive data dictionary as defined by the Department.
- The MCO must provide all necessary data, information, and services in the format defined by Department, and HIPAA-compliant.
- The MCO must provide all of the data, information, and services mentioned in this section using its best efforts to ensure the efficient administration of the Contract. The data and information must be supplied in the media format specified by Department and according to the schedule approved by Department in the Transition Plan.
- If the MCO does not provide the required data, information, documentation or services necessary for the Department or the subsequent contractor to assume the operational activities successfully, the MCO must reimburse the Department for all reasonable costs and expenses, including: transportation; lodging; subsistence to carry out inspection, audit, review, analysis, reproduction, and transfer functions at the location(s) of any necessary records; and attorneys' fees and costs.

This provision does not limit the Department's ability to impose remedies as set forth in the Contract.

#### **6.16 Cooperation with Other Contractors and Prospective Contractors**

The MCO must cooperate with other DHHR contractors and MCOs and will not commit or permit any act that may interfere with the performance of work by any other contractor or prospective MCO.

#### **6.17 Waiver of Default or Breach**

Waiver of any default will not be deemed to be a waiver of any subsequent default. Waiver of breach of any provision of the Contract will not be deemed to be a waiver of any other or subsequent breach and will not be construed to be a modification of the terms of the Contract

unless stated to be such in writing, signed by an authorized representative of the Department and the MCO, and attached to the original contract.

### **6.18 Severability**

If any provision of this Contract is declared or found to be illegal, unenforceable, or void, then both parties will be relieved of all obligations under that provision. The remainder of this Contract will be enforced to the fullest extent permitted by law.

### **6.19 Modification of the Contract in the Event of Remedies**

The Department may propose a modification of this Contract in response to the imposition of a remedy under this Article. Any modifications must be reasonable, limited to the matters causing the exercise of a remedy and must be in writing.

## **7. POST-AWARD READINESS REVIEW**

The MCO must satisfy all Readiness Review requirements as outlined in 42 CFR 438.66 and provided by the Department prior to the MCO or its Subcontractor(s) operational start date(s). The Department or its agents will conduct a Readiness Review to determine whether the MCO or its Subcontractor(s) have implemented all systems and processes necessary to begin serving enrollees.

A Readiness Review by the Department or its designated agent may occur if:

1. A new MCO is contracted by the Department;
2. A new Subcontractor is employed by the MCO;
3. An existing MCO or its Subcontractor provides services in a new service area;
4. An existing MCO or its Subcontractor provides services for a new MCO program or population;
5. An existing MCO or its Subcontractor changes locations;
6. An existing MCO or its Subcontractor changes one (1) or more of its information management systems, claims processing or operational functions; or
7. A Readiness Review is requested by the Department, CMS, or ACF.

The Department, may, at its discretion, terminate the Contract, postpone the operational start date(s), or assess other contractual remedies if an MCO or its Subcontractors fail to timely correct all Readiness Review deficiencies within a reasonable cure period, as determined by the Department.

## **8. OTHER REQUIREMENTS**

### **8.1 Inspection of Facilities**

The MCO and its Subcontractors must provide the State of West Virginia, CMS, ACF, the Office of the Inspector General and any other legally authorized governmental entity or their authorized representatives, the right to enter the MCO's and its Subcontractors' premises, physical facilities and equipment or other places where work under this Contract is performed to inspect, monitor

or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this Contract. The State of West Virginia, CMS, ACF, the Office of the Inspector General, and any other legally authorized governmental entity may conduct such inspections at any time.

The MCO and its Subcontractors must provide reasonable facilities and assistance for the safety and convenience of the persons performing those duties (e.g., assistance from MCO staff to retrieve and/or copy materials). DHHR and its authorized agents will request access in writing except in case of suspected fraud, waste, and abuse. All inspection, monitoring, and evaluation must be performed in such a manner as not to unduly interfere with the work being performed under this contract.

In the event that right of access is requested under this section, the MCO or its Subcontractors must, upon request, provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the State or Federal representatives conducting the audit or inspection effort.

All inspections or audits will be conducted in a manner that will not unduly interfere with the performance of the MCO or any Subcontractors' activities. The MCO and its Subcontractors will be given ten (10) business days to respond to any findings of an audit before DHHR will finalize its findings. All information so obtained will be accorded confidential treatment as provided under applicable law.

Any Subcontract with an approved MCO Subcontractor must include a provision specifically authorizing inspection in accordance with the terms set forth in this Section.

## **8.2 MCO Requirements Related to Information Systems**

The MCO must clearly define and document the policies and procedures that will be followed to support day-to-day systems activities. The MCO must develop and maintain the following documents:

1. Disaster Recovery Plan;
2. Business Continuity Plan;
3. Information Security Plan; and
4. Systems Quality Assurance Plan.

The MCO must provide a copy of these documents within ten (10) business days of written request from DHHR.

## **8.3 Maintenance and Examination of Records**

The MCO and its Subcontractors must maintain records, books, documents, papers and files that are related to West Virginia's managed care program services and expenditures, including reports to DHHR and source information used in preparation of these reports. These reports include but are not limited to financial statements, records relating to quality of care, and medical records. In addition, the MCO must provide, and cause its Subcontractors to provide, at no cost to DHHR or a designee, prompt, reasonable, and adequate access to any records, books, documents, papers and files that are related to performance under the Contract. The MCO and its

Subcontractors agrees to permit inspection of its records, books, documents, papers and files which will be conducted in accordance with Federal and State laws and regulations regarding confidentiality. The MCO and its Subcontractors are required to submit information to DHHR or to a designee in a manner that maintains the confidentiality of involved parties (e.g., blacking out enrollees' and providers' names). The MCO must comply with the record retention requirements of Title 45, Sections 74.21 through 74.23 (45 CFR 74.21 through 74.23) and FISMA. Such records, with the exception of medical records and enrollee and provider quality assurance and quality improvement records when confidentiality is protected by law, are the property of DHHR.

CMS, the Office of Inspector General, the Comptroller General, the Secretary, DHHR or their designees have the right to audit and inspect any books or records of the MCO or its Subcontractors pertaining to the ability of the MCO to bear the risk of financial losses and services performed or payable amounts under the Contract.

Upon non-renewal or termination of this Contract, the MCO must turn over, and cause its Subcontractors to turn over, to DHHR or to a designee of DHHR all records, books, documents, papers and files that are related to persons receiving services and to the administration of this Contract that DHHR may request.

The MCO must provide, and cause its Subcontractors to provide, CMS, OIG, the Comptroller General, the DHHR and its authorized agents with reasonable access to any records, books, documents, papers and files the MCO and its Subcontractors maintain for the purposes of this Contract. DHHR and its authorized agents will request access in writing except in cases of suspected fraud, waste, and abuse. The MCO and its Subcontractors must make all requested medical records available within ten (10) business days of DHHR's request.

Any Subcontract with an approved MCO Subcontractor must include a provision specifically authorizing maintenance and examination of records in accordance with the terms set forth in this Section.

#### **8.4 Audit Accounting and Retention of Records**

DHHR may, at its option, conduct an audit of the MCO's and its Subcontractors' operations as they pertain to services and recoveries pursuant to the contracted services.

The MCO and its Subcontractors, for purposes of audit, must provide the State of West Virginia, the Secretary of the U.S. Department of Health and Human Services, the OIG, the Comptroller General and his/her designated agent, and any other legally authorized governmental entity or their authorized agents access to all the MCO and its Subcontractors' materials and information pertinent to the services provided under this Contract, at any time, until the expiration of ten years from the completion date of this Contract as extended or ten years from the completion date of any audit, if longer. The MCO agrees to comply with the provisions of Section 1861 (v)(1)(I) of the Social Security Act, as amended, governing the maintenance of documentation to verify the cost of services rendered under this Contract. The MCO and its Subcontractors agree that authorized State representatives including, but not limited to, Department personnel, the State Auditor, and other State and/or any applicable Federal agencies providing funds will have access to and the right to examine the items listed above during the Contract period and during

the ten (10) year post-Contract period, or ten (10) years after the date of the final resolution of all pending audit questions and litigation, if longer. During the Contract period, access to these items will be provided to DHHR or its designee at all reasonable times. This may require the identification and collection of data for use by medical audit personnel. During the ten-year post-Contract or post-audit period, delivery of and access to the listed items will be at no cost to the State.

The State and its authorized agents may record any information and make copies of any materials maintained for the purposes of this Contract necessary for the audit, except enrollee and provider quality assurance and quality improvement records when confidentiality is protected by law.

Any Subcontract with an approved MCO Subcontractor must include a provision specifically authorizing audits in accordance with the terms set forth in this Section.

#### ***8.4.1 Accounting***

The MCO and its Subcontractors must maintain accounting records relating to the performance of the Contract. These accounting records must be maintained in accordance with generally accepted accounting principles.

#### ***8.4.2 Separate Accounting Records***

The MCO and its Subcontractors must maintain separate books, records, documents, files and other evidence pertaining to the administrative costs and expenses of the Contract to the extent and in such detail as must properly reflect all revenues and all costs of whatever nature for which reimbursement is claimed under the provisions of the Contract. All such documents must be made available to DHHR or its designee at its request and must be clearly identifiable as pertaining to the Contract.

#### ***8.4.3 Retention of Records***

All financial and programmatic records, supporting documents, files, statistical records, and other records of enrollees, which are required to be maintained by the terms of this Contract and by 42 CFR 438.416, 438.5(c), 438.8(k), and 438.604, 438.606, and 438.610., must be retained for at least ten years from the date of expiration or until ten years after the date on which any on-going audits have been settled, if longer. If any litigation, claim, negotiation, audit, or other action involving the records has been started before the expiration of the ten year period, the records must be retained until ten years after the completion of the action and resolution of all issues which arise from it, or until the end of the regular ten year period, whichever is later. The MCO and its Subcontractors agree to retain the source records for its data reports for a minimum of ten years and must have written policies and procedures for storing this information.

### **8.5 Subcontracts**

The MCO may enter into a Subcontract agreement to fulfill the requirements of this Contract. Subcontracts must comply with the requirements of 42 CFR 434.6 and 42 CFR 438.230. Prior to delegating functions of the Contract, the MCO must evaluate the Subcontractor's ability to perform the functions.

All Subcontracts must be in writing and include the ability for the MCO to revoke the Subcontract or impose sanctions if the Subcontractor's performance is inadequate. The MCO must provide the Department or its authorized agents the right to examine any current or former Subcontract and all Subcontractor records relating to this Contract at any time. A Subcontract, or any other agreement in which the MCO receives rebates, recoupments, discounts, payments, incentives, fees, free goods, bundling arrangements, or any other consideration from a Subcontractor or any other third party as related to this Contract must be in writing and agreed upon in compliance with the MCO's Contract obligations. The MCO must allow the Department or its authorized agents to examine the Subcontractor agreement and all related records.

The MCO Subcontract agreement must include any applicable requirements of this Contract that are appropriate to the services being provided and must assure that all delegated duties under the Subcontract are performed to the same extent as if such were performed by the MCO. Subcontracts must not terminate legal liability of the MCO under this Contract including but not limited to Article II, Section 6 of this Contract. The Department reserves the right to review all Subcontracts and/or any significant modifications to previously approved Subcontracts. The MCO is required to submit utilization review and claims processing Subcontracts ninety (90) calendar days prior to the effective date of the Subcontract for the Department review and approval.

The MCO may not modify, convey, sell, transfer, assign, delegate, or otherwise dispose of the Contract or any portion thereof or of any right, title, or interest therein without the prior written consent of the Department. This provision includes reassignment of the Contract due to change in ownership of the MCO. The Department in its discretion may grant such written approval of an assignment, transfer, delegation or Subcontract, provided, however, that this paragraph may not be construed to grant the MCO any right to such approval. This paragraph may not be construed as restricting the MCO from entering into contracts with participating providers to provide health care services to plan enrollees.

The Department reserves the right to require the replacement of any Subcontractor found by the Department to be unacceptable and unable to meet the requirements of the Contract and to object to the selection of a Subcontractor. The Department reserves the right to require the CAP for any Subcontractor found by the Department to be unable to meet the requirements of this Contract.

The Department reserves the right to disallow a proposed subcontracting arrangement if the proposed Subcontractor has been formally restricted from participating in a federal entitlement program (i.e., Medicare, Medicaid, and programs through ACF).

The MCO must submit a report listing each Subcontract, Subcontractor name, Subcontract effective dates and functions by July 1<sup>st</sup> of every year to the Department.

The requirements of this Section do not apply to Subcontracts entered into for the provision of any of the following: utilities (e.g., water, electricity, telephone, Internet), mail/shipping, office space, or computer hardware.

The MCO's Subcontract agreement must require a written notice of intent to be furnished by the MCO or its Subcontractor in case of the Subcontract termination for any reason. A written notice of intent must be given within the following timeframes:

- Ninety (90) calendar days prior to the termination date of a Subcontract for systems operations or reporting;
- Thirty (30) calendar days prior to the termination date of a Subcontract for administrative services; and
- Thirty (30) calendar days prior to the termination date of any other Subcontract.

A written notice of intent is not required in case of a serious breach of a Subcontract. The MCO must provide the Department with a written notification no later than three (3) business days if a serious breach of a Subcontract occurs.

The MCO must provide the Department with a written notification no later than five (5) business days after receiving a written notice from a Subcontractor or giving a notice to Subcontractor of the intent to terminate a Subcontract for any reason.

Subcontracts must provide that all information that is obtained through performance under this Contract, including, but not limited to, information relating to applicants or enrollees of the Department programs, is confidential to the extent that confidential treatment is provided under state and federal law, rules, and regulations.

The MCO must maintain and keep current a Subcontractor monitoring plan for each of its Subcontractors listed above. The MCO must provide a copy of its Subcontractor monitoring plan within ten (10) business days of the Department written request. The MCO is required to monitor the Subcontractor's performance on an ongoing basis consistent with 42 CFR §438.230.

The MCO is solely responsible for the fulfillment of this Contract with the Department. The MCO is required to assume prime contractor responsibility for all services offered and products to be delivered whether or not the MCO is the provider of said services or product. The Department will consider the MCO to be the sole point of contact with regard to all contractual matters.

## **8.6 Insurance**

The MCO, its successors and assignees must procure and maintain such insurance as is required by currently applicable federal and state law and regulation. Such insurance should include, but not be limited to, the following:

1. Liability insurance for loss, damage, or injury (including death) of third parties arising from acts and omissions on the part of the MCO, its agents and employees;
2. Fidelity bonding of persons entrusted with handling of funds;
3. Workers compensation;
4. Unemployment insurance; and
5. Adequate reinsurance or a restricted fund balance for the purpose of self-insurance for financial risks accepted.

## **8.7 Disclosure of Ownership**

The MCO, as a “disclosing entity,” must supply DHHR with full and complete information of each person (individual or corporation) with an ownership or control interest in the MCO or the MCO’s Subcontractor in which the MCO has direct or indirect ownership as outlined below and in accordance with 42 CFR 455.104.

The MCO and its subcontractors are required to disclose to the state any persons or corporations with an ownership or control interest in the MCO that:

1. Has direct, indirect, or combined direct/indirect ownership interest of five percent (5%) or more of the MCO’s equity;
2. Owns five percent (5%) or more of any mortgage, deed of trust, note, or other obligation secured by the MCO if that interest equals at least five percent (5%) of the value of the MCO’s assets;
3. Is an officer or director of an MCO organized as a corporation; or
4. Is a partner in an MCO organized as a partnership?

### **8.7.1 Disclosure Report Requirements**

This disclosure must include for each person:

- The name and address of the person, including the primary business address, every business location, and P.O. Box address, as applicable;
- Date of birth and Social Security Number (SSN) (in the case of an individual);
- Tax identification number for a corporation with an ownership or control interest in the MCO or for a Subcontractor in which the MCO has a five percent (5%) or more interest;
- Whether the person (individual or corporation) with ownership or control interest in the disclosing entity and/or Subcontractor is related to any other person with ownership or control interest such as a spouse, parent, child, or sibling;
- The name of any other organization in which a person with ownership or control interest in the MCO also has an ownership or control interest; and
- The name, address, date of birth, and SSN of an agent or a managing employee of the disclosing entity.

### **8.7.2 Disclosure Reporting Schedule**

The MCO must disclose information on individuals or corporations with an ownership or control interest in the MCO to the Department at the following times:

1. When the MCO submits a proposal in accordance with the state’s procurement process;
2. When the MCO executes a contract with the Department;

3. When the state renews or extends the MCO contract;
4. Within thirty-five (35) calendar days after any change in ownership of the MCO;  
and
5. Within thirty-five (35) calendar days of the Department's request.

The MCO must also submit to DHHR a copy of any information it submits to the Department of Insurance regarding disclosure of ownership or control interest.

#### ***8.7.3 Prohibited Affiliations with Individuals Debarred by Federal Agencies***

The MCO may not have a director, officer, principal, partner, agent, managing employee, or other person with ownership or control interest of five percent (5%) or more in the MCO and who:

- Has been convicted of a criminal offense as described in sections 1128(a) and 1128(b) (1), (2), or (3), of the Social Security Act;
- Has had civil money penalties or assessments imposed under section 1128A of the Social Security Act; or
- Has been excluded, suspended, or debarred from participation in Medicare or any state health care programs.

The MCO must submit information as described above, for any person who was formerly described as a director, officer, principal, partner, agent, managing employee, or other person with ownership or control interest of five percent (5%) or more in the MCO, but is no longer so described because of a transfer of ownership or control interest to an immediate family member or a member of the person's household, in anticipation of or following a conviction, assessment of a civil monetary penalty, or imposition of an exclusion.

The MCO is prohibited from having a consulting, employment, or other agreement with an excluded, debarred or suspended person for the provision of items or services that are significant and material to the MCO's contractual obligation with the State. Likewise, the MCO may not have a relationship with an affiliate of any person described above.

Entities that meet any of the following criteria must be excluded from participation:

1. Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;
2. Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;
3. Employs or contracts directly or indirectly with an individual or entity that is:
  - a. Precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or
  - b. Could be exclude under 1128(b)(8) as being controlled by a sanctioned individual.

The MCO must immediately inform DHHR of any circumstances that are grounds for its exclusion, or the exclusion of its contracted providers, from participation in the Medicaid program, in accordance with 42 CFR 1001.1001 and 42 CFR 1001.1051.

At the time of Contract and Contract renewal or upon written request by DHHR, the MCO must submit information on any person who is a director, officer, principal, partner, agent, managing employee, or other person with ownership or control interest of five percent (5%) or more in the MCO and who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs, as required in 42 CFR 455.106.

If DHHR finds that the MCO is not in compliance with this provision, DHHR: (1) will notify the Secretary of the Department of Health and Human Services of such noncompliance; (2) may discontinue the existing agreement with the MCO if so directed by the Secretary (in consultation with the Inspector General of the Department of Health and Human Services); and (3) will not renew or otherwise extend the duration of the existing agreement with the MCO unless the Secretary (in consultation with the Inspector General) provides to DHHR and to Congress a written statement describing compelling reasons that exist for doing so.

#### ***8.7.4 Business Transactions of Medicaid Providers***

Federal regulations contained in 42 CFR 455.105 require the MCO to disclose the following information related to business transactions within thirty-five (35) calendar days of request of the Secretary of DHHS: full and complete information about (1) the ownership of any Subcontractor with whom the MCO has had business transactions totaling more than \$25,000 during the previous twelve (12) month period and (2) any significant business transactions between the MCO and any wholly owned supplier, or between the MCO and any Subcontractor, during the previous five (5) years.

### **8.8 Disclosure of Legal Proceedings and Related Events**

The MCO must notify the Department of all legal proceedings, actions, and events relating to the MCO or its Subcontractors, affiliates, including parent companies. At a minimum, the following matters must be disclosed:

1. Whistleblower or qui tam actions, complaints, or litigation;
2. Class-action complaints or lawsuits;
3. Legal actions or governmental investigations, alleging fraud or the possibility of fraud;
4. Bankruptcy proceedings or petitions where the MCO, or its Subcontractors, affiliates, including parent companies, are named as a debtor;
5. Any litigation, mediation, arbitration, between the MCO and its Subcontractor; and
6. Criminal actions brought against the MCO, or its Subcontractors, affiliates, including parent companies.

The MCO must provide written notification within thirty (30) calendar days after becoming aware of a matter. A summary, in the form of a memo, must meet the requirements of

notification to DHHR. All other legal proceedings, actions, and events may be requested at the DHHR's discretion, but are not required to be reported upon awareness of occurrence.

**9. SIGNATURES**

Each party accepts the Agreement's terms as formally acknowledged below:

**West Virginia Department of Health and Human Resources**

Signature: Jeff Wiseman

Printed Name: Jeff Wiseman

Title: Asst to the Deputy Secretary

Date: 2/4/20

**State of West Virginia, Department of Administration Purchasing Division**

Signature: Tara Lyk

Printed Name: Tara Lyk

Title: Buyer Supervisor

Date: 2/7/2020

**Managed Care Organization**

Signature: R. M. Kessler

Printed Name: Robert M. Kessler

Title: Vice President and Secretary

Date: February 3, 2020

## **ARTICLE III: STATEMENT OF WORK**

### **1. COVERED POPULATIONS**

The following populations will be served by the MCO:

- Children and youth who are in foster care (effective March 1, 2020);
- Individuals receiving adoption assistance (effective March 1, 2020);
- Children from three (3) up to age twenty-one (21) eligible for the SED waiver and enrolled in the MCO as slots are available (effective March 1, 2020);

### **2. COVERED SERVICES**

#### **2.1 Covered MCO Services**

The MCO must provide to enrollees enrolled under this Contract, directly or through arrangements with others, all of the covered services described in Contract Appendix A (Description of Covered and Excluded Services). Contract Appendix A presents an explanation of the medical, dental, behavioral health, and residential, which the MCO is required to provide, as well as those which are excluded. It also includes the types of SNS services provided through the ASO. However, the Medicaid policy is the final source for defining Medicaid covered services. Medicaid policy collectively refers to documents and other written materials including the State Medicaid plan, applicable Medicaid waivers, program instructions, attendant provider manuals, program bulletins, and all published policy decisions issued by BMS. These Medicaid materials are available through BMS. The Title IV State Plan is the final source for defining services covered under the child welfare umbrella.

The MCO must promptly provide or arrange to make available for enrollees all Medically Necessary and SNS listed in Contract Appendix A. The MCO shall be financially responsible for the coverage of all Medicaid services as defined by Appendix A. The MCO is responsible for determining whether services are Medically or Socially Necessary and whether the MCO will require prior approval for services. Qualified medical personnel must be accessible twenty-four (24) hours each day, seven (7) days a week, to provide direction to patients in need of urgent or emergency care. Such medical personnel include, but are not limited to, physicians, physicians on-call, PAs, licensed practical nurses (LPNs), and registered nurses (RNs). The MCO is also responsible for providing emergency transportation as outlined in Article III, Section 2.2.4 and in Appendix A.

Additionally, the MCO's providers must meet the provider requirements as specified by the West Virginia Medicaid program.

The MCO will be at "risk" for the services listed in Contract Appendix A (Description of Covered and Excluded Services) through a capitation payment system. In addition, the MCO will receive a fixed monthly payment for ASO services.

The MCO must provide covered services to Medicaid enrollees under this Contract in the same manner as those services are provided to other enrollees of the MCO, although delivery sites, covered services, and provider payment levels may vary. The MCO must guarantee that the

locations of facilities and practitioners providing health care services to enrollees are sufficient in terms of geographic convenience to low-income areas, handicapped accessibility, and proximity to public transportation routes, where available. The MCO is prohibited from refusing to provide or assume financial responsibility for any covered service listed in Contract Appendix A because of moral or religious objections.

Changes to Medicaid or SNS covered services mandated by Federal or State law subsequent to the signing of this Contract will not affect the Contract services for the term of this contract, unless (1) agreed to by mutual consent, or (2) unless the change is necessary to continue to receive Federal funds or due to action of a court of law. For example, if Medicaid coverage were expanded to include new services, such services would be paid for via the traditional Medicaid FFS system unless covered by mutual consent between DHHR and the MCO (in which case an appropriate adjustment to the payment rates would be made).

## **2.2 Additional Requirements/Provisions for Certain Services**

### ***2.2.1 Initial Health Assessment, Comprehensive Exam, and Follow-up Requirements for Children Entering or Re-entering Foster Care***

All children entering or re-entering Foster Care must have:

- A comprehensive Early and Periodic Screening, Diagnosis and Treatment (EPSDT) exam within thirty (30) calendar days of placement in Foster Care; and
- A follow-up visit within ninety (90) calendar days of placement in Foster Care, as needed.

Once the child is enrolled in the MCO, the MCO will be responsible for working with the assigned CPS worker to ensure these important health assessments, exams, and follow-up visits are performed timely.

### ***2.2.2 Initial Health Assessment for Other Enrollees Not in Foster Care***

For all other MCO enrollees not newly entering or re-entering foster care, the MCO must ensure that an initial screening of each enrollee's health care needs is completed within ninety (90) calendar days of the effective date of enrollment.

### ***2.2.3 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services***

The Omnibus Budget Reconciliation Act of 1989 (OBRA 89) mandated that all Medically Necessary services listed in section 1905(a) of the Social Security Act be covered under Medicaid for the EPSDT benefit provided for Medicaid eligible children under the age of twenty-one (21). EPSDT services are included in the prepaid benefit package for children and adolescents up to age twenty-one (21). The federal government, through the CMS, requires states to demonstrate an eighty percent (80%) compliance rate for EPSDT screening schedules.

In West Virginia, EPSDT is called HealthCheck. The MCO is responsible for working with parents, caregivers, and CPS workers to ensure all children and youth covered through this contract receive the EPSDT HealthCheck screenings according to the periodicity schedule or as determined to be medically necessary for the child.

### *2.2.3.1 EPSDT HealthCheck Requirements for the MCO*

The MCO is required to:

1. Provide notification of screening due dates to the enrollee or his representative;
2. Perform the screenings according to the State-determined periodicity schedule;
3. Make the necessary referrals;
4. Track referrals and treatments;
5. Report the results via the encounter reporting system; and
6. Report results as necessary to meet federal requirements, as requested by DHHR.

The MCO must have written policies and procedures for providing the full range of EPSDT services to all eligible children and young adults up to age twenty-one (21). This information must be available for the hearing- and visually-impaired. Translation services should be made available as necessary. The full scope of EPSDT service requirements is described below.

### *2.2.3.2 Provide Information on EPSDT HealthCheck and Notification of Screening Due Dates*

The MCO must provide a combination of written and oral methods designed to effectively inform all EPSDT-eligible individuals, their families, and their foster care parents, and CPS worker if applicable about the EPSDT program. MCOs must have an established process for reminders, follow-ups, and outreach to EPSDT service enrollees.

The MCO, or designee if collaborating with the Bureau for Public Health, must inform all EPSDT eligible individuals or their representatives about the EPSDT program using clear and non-technical language. The MCO must meet the federal EPSDT informing requirements as specified in 42 CFR 441.56 and must provide information that includes the following:

1. The benefits of preventive health care;
2. The services available under the EPSDT program and where and how to obtain those services;
3. A statement that the services provided under the EPSDT program are without cost to eligible individuals under twenty-one (21) years of age; and
4. A statement that necessary transportation and scheduling assistance is available to the EPSDT eligible individual upon request (Medicaid related non-emergency transportation is paid by the Department outside of the MCO capitation system).

### *2.2.3.3 Perform the EPSDT HealthCheck Screenings*

MCOs must provide screenings (periodic comprehensive child health assessments) according to the West Virginia Periodicity Schedule to all enrollees eligible to receive them. The Periodicity Schedule is maintained by the Office of Maternal and Child Health within the Bureau for Public Health at DHHR and corresponds to the AAP's Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents.

Covered screening services are regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. At a minimum, the EPSDT HealthCheck screenings must include, but are not limited to:

1. A comprehensive health and developmental history (including assessment of both physical and mental health development);
2. An unclothed physical exam;
3. Laboratory tests (including blood lead screening appropriate for age and risk factors);
4. Vision testing;
5. Appropriate immunizations, in accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices (ACIP);
6. Hearing testing;
7. Dental services (furnished by direct referral to a dentist for children beginning beginning six (6) months after the first tooth erupts or by twelve (12) months of age );
8. Behavioral health screening; and
9. Health education (including anticipatory guidance).

MCOs must also provide interperiodic screenings, which are any encounters with a health professional practicing within the scope of his or her practice and who provides Medically Necessary health care, diagnosis, or treatment to determine the existence of a suspected illness or condition, or a change or complication to a pre-existing condition. The interperiodic screen is used to determine if there is a problem that was not evident at the time of the regularly scheduled screen but needs to be addressed before the next scheduled screen.

#### *2.2.3.4 Make the Necessary Referrals*

In addition to any diagnostic and treatment services included in the defined EPSDT benefit package, the MCO must provide the following services to eligible enrollees, if the need for such services is indicated by screening:

1. Diagnosis of and treatment for defects in vision and hearing;
2. Dental care (at as early an age as necessary) needed for relief of pain and infections, restoration of teeth, and/or maintenance of dental health; and
3. Appropriate immunizations (if it is determined at the time of screening that immunization is needed and appropriate to provide at that time, then immunization treatment must be provided at the time of screening).

If a suspected problem is detected during an EPSDT HealthCheck screening examination, the child must be evaluated as necessary for further diagnosis. This diagnosis is used to determine treatment needs.

The MCO is financially responsible for providing such other necessary health care and all follow-up diagnostic and treatment services deemed Medically Necessary to ameliorate or correct defects and physical and mental illnesses and conditions discovered by the screening

services. Medically necessary services must be contained within the categories of mandatory and optional services listed in Section 1905(a) of the Social Security Act, whether or not such services are covered under the State Plan.

Per 42 CFR 441.61(a), in the event a child needs a treatment that is not coverable under the categories listed in Section 1905(a) of the Social Security Act, the MCO must provide referral assistance that includes giving the family or beneficiary the names, addresses, and telephone numbers of providers who have expressed a willingness to furnish uncovered services at little or no expense to the family.

The MCO is responsible for determining if covered services are Medically Necessary. The determination of whether a service is Medically Necessary for an individual child must be made on a case-by-case basis, taking into account the particular needs of the child. Because medical necessity decisions are individualized, flat limits or hard limits based on a monetary cap or budgetary constraints are not consistent with EPSDT requirements.

#### *2.2.3.5 Track EPSDT HealthCheck Referrals and Treatments*

MCOs must establish a tracking system that provides up-to-date information on compliance with EPSDT service provision requirements including a Periodicity Schedule of preventive services and standards of care in the following areas:

1. Initial visit for newborns. The initial EPSDT screen must be the newborn physical exam in the hospital, birthing center, at home or other setting. Based in part upon the results of the birth score procedure conducted through the hospital or birthing center under the auspices of the Bureau for Public Health, the periodicity of preventive pediatric visits must follow schedule recommended by the AAP or the accelerated visit schedule set for infants identified as “at risk” through the birth score system.
2. Preventive pediatric visits according to the West Virginia’s Periodicity Schedule up to age twenty-one (21).
3. Diagnosis and/or treatment, or other referral in accordance with EPSDT screen results. The MCO must employ processes to ensure timely initiation of treatment, if required, generally within an outer limit of six (6) months after the screening services.

#### *2.2.3.6 Report the EPSDT HealthCheck Results*

The Department is responsible for ensuring that the MCO fulfills its contractual responsibilities to inform all families of the services available under EPSDT and how to access them.

MCOs must submit to DHHR a report due forty-five (45) calendar days after the end of each quarter which identifies its performance regarding EPSDT outreach/enabling services, screening and referral rates, well-care child visit rates, dental visits, and immunization rates (see Section 6.10, Reporting Requirements).

#### **2.2.4 Emergency Care**

MCO policy and procedures, covered Medicaid services, claims adjudication methodology, and reimbursement performance for emergency care services must comply with all applicable state and federal laws, rules, and regulations, including 42 CFR 438.114, whether the provider is in

the MCO's network or out-of-network. The MCO must cover and pay for all medical, behavioral, inpatient pharmacy, dental services, and emergency transportation described in Contract Appendix A that may be required on an emergency basis twenty-four (24) hours each day, seven (7) days a week, either in the MCO's facilities or through arrangements approved by DHHR.<sup>2</sup> The terms "Emergency Care," "Urgent Care," "Emergency Medical Conditions," and "Emergency Dental Condition" are defined in Article II of this Contract.

Reimbursement for emergency services provided out-of-network must be equal to the Medicaid prevailing FFS reimbursement level for emergency services, less any payments for direct costs of medical education and direct costs of graduate medical education included in the FFS reimbursement rate. In emergency situations, no pre-authorization is required to provide necessary medical care and enrollees may seek care from non-participating providers.

The MCO must reimburse for Medicaid emergency transportation at a rate of at least one-hundred percent (100%) of the Medicaid fee schedule for emergency ground transportation and emergency air transportation.

The MCO is required to inform enrollees or their representatives regarding their rights of access to and coverage of emergency services, both inside and outside of the plan's network.

Coverage of emergency services by the MCO will be determined under the "prudent layperson" standard. That standard considers the symptoms (including severe pain) of the presenting enrollee. The MCO may not limit what constitutes an Emergency Medical or Behavioral Health Condition on the basis of lists of diagnoses or symptoms.

The MCO may not deny payment for treatment obtained when an enrollee had an emergency medical or dental condition in which the absence of immediate medical attention would have placed the health of the individual, or in the case of a pregnant woman, the woman or her unborn child, in serious jeopardy; resulted in serious impairment to bodily functions; or resulted in serious dysfunction of any bodily organ or part. The MCO may not deny payment for treatment when a representative of the MCO instructs the enrollee to seek emergency care.

The MCO may not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard (as defined above), turned out to be non-emergency in nature. Hospitals are required to evaluate each enrollee presenting for services in the emergency room and must be reimbursed for this evaluation. If emergency room care is later deemed non-emergency, the MCO is not permitted to bill the Medicaid patient; the MCO and the hospital should determine who pays for this care, except for the applicable non-emergency copays paid by the enrollee.

The MCO may not require prior authorization for emergency services. This applies to out-of-network as well as to in-network services which an enrollee seeks in an emergency. Placement in

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<sup>2</sup> Qualified medical personnel must be accessible twenty-four (24) hours each day, seven (7) days a week, to provide direction to patients in need of urgent or emergency care. Such medical personnel include, but are not limited to, physicians, physicians on-call, licensed practical nurses, or registered nurses.

an IMD is considered an emergency services and as such, the MCO cannot require a prior authorization for placement in the IMD the first forty-eight (48) hours.

A medical screening examination needed to diagnose an enrollee's emergency medical condition must be provided in a hospital-based emergency department that meets the requirements of the Emergency Medical Treatment and Active Labor Act (EMTALA) (42 CFR 489.20, 489.24 and 438.114(b)&(c)). The MCO must pay for the enrollee's emergency medical screening examination, as required by 42 U.S.C. 1395dd. The MCO must reimburse the providers for both the physician's services and the hospital's emergency services, including the emergency room and its ancillary services, so long as the "prudent layperson" standard (as defined above) has been met.

### **2.2.5 Post-Stabilization Care**

The MCO must cover and pay for post-stabilization care services in the amount, duration, and scope necessary to comply with 42 CFR 438.114 and 42 CFR 422.113(c).

These regulations state that the MCO must make timely and reasonable payment to or on behalf of the plan enrollee for the following services obtained from a provider or supplier whether or not that provider or supplier contracts with the MCO to provide services covered by the MCO. Post-stabilization care services are covered services that:

- Were pre-approved by the organization; or
- Were not pre-approved by the organization because the organization did not respond to the provider of post-stabilization care services' request for pre-approval within one (1) hour after being requested to approve such care or could not be contacted for pre-approval.

Post-stabilization services are not "emergency services," which the MCO is obligated to cover in-or-out of plan according to the "prudent layperson" standard. Rather, they are non-emergency services that the MCO could choose not to cover out-of-plan except in the circumstances described above.

The intent of this provision is to promote efficient and timely coordination of appropriate care of a managed care enrollee after the enrollee's condition has been determined to be stable.

### **2.2.6 Family Planning**

The MCO must ensure that its network includes sufficient family planning providers to ensure timely access to covered family planning services for enrollees. Although family planning services are included within the MCO's list of covered benefits, Medicaid enrollees are entitled to obtain all Medicaid covered family planning services without prior authorization through any Medicaid provider, who will bill the MCO and be paid on a FFS basis.<sup>3</sup>

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<sup>3</sup> Access to family planning services without prior notification is a federal law. Under OBRA 1987 Section 4113(c)(1)(B), "enrollment of an individual eligible for medical assistance in a primary case management system, a health maintenance organization or a similar entity must not restrict the choice of the qualified person, from whom the individual may receive services under Section 1905(a)(4)(c)." Therefore, Medicaid enrollees

The MCO must give each enrollee, including adolescents, the opportunity to use his/her own primary care provider or go to any family planning center for family planning services without requiring a referral. The MCO must make a reasonable effort to subcontract with all local family planning clinics and providers, including those funded by Title X of the Public Health Services Act, and must reimburse providers for all family planning services regardless of whether they are rendered by a participating or non-participating provider. Unless otherwise negotiated, the MCO must reimburse providers of family planning services at the Medicaid rate. The MCO may, however, at its discretion, impose a withhold on a contracted primary care provider for such family planning services. The MCO may require family planning providers to submit claims or reports in specified formats before reimbursing services.

MCOs must provide their Medicaid enrollees with sufficient information to allow them to make an informed choice including: the types of family planning services available, the availability of long-acting reversible contraceptives (LARC), their right to access these services in a timely and confidential manner, and their freedom to choose a qualified family planning provider both within and outside the MCO's network of providers. In addition, MCOs must ensure that network procedures for accessing family planning services are convenient and easily comprehensible to enrollees. MCOs must also educate enrollees regarding the positive impact of coordinated care on their health outcomes, so enrollees will prefer to access in-network services or, if they should decide to see out-of-network providers, they will agree to the exchange of medical information between providers for better coordination of care.

In addition, MCOs are required to provide timely reimbursement for out-of-network family planning and related STD services consistent with services covered in their contracts. The reimbursement must be provided at least at the applicable West Virginia Medicaid FFS rate appropriate to the provider type (current family planning services fee schedule available from DHHR).

The MCO, its staff, contracted providers and its contractors that are providing cost, quality, or medical appropriateness reviews or coordination of benefits or subrogation must keep family planning information and records confidential in favor of the individual patient, even if the patient is a minor. The MCO, its staff, contracted providers and its contractors that are providing cost, quality, or medical appropriateness reviews, or coordination of benefits or subrogation must also keep family planning information and records received from non-participating providers confidential in favor of the individual patient even if the patient is a minor. Maternity services, hysterectomies, and pregnancy terminations are not considered family planning services.

#### *2.2.6.1 Conditions for Out-of-Network Reimbursement of Family Planning Services*

All MCOs must reimburse out-of-network providers for family planning services rendered to enrollees. Unless otherwise negotiated, the MCO must reimburse providers of family planning services at the Medicaid rate. The following are the conditions under which family planning providers will be reimbursed for family planning services provided to Medicaid enrollees:

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must be allowed freedom of choice of family planning providers and may receive such services from any family planning provider, including those outside the MCO's provider network, without prior authorization.

1. The family planning provider must be qualified to provide family planning services based on licensed scope of practice;
2. The family planning provider must submit claims on appropriate MCO-specific billing forms; and
3. The family planning provider must provide medical records sufficient to allow the MCO to meet its case management responsibilities. If an enrollee refuses the release of medical information, the out-of-network provider must submit documentation of such refusal.

In order to avoid duplication of services, promote continuity of care, and achieve the optimum clinical outcome for Medicaid enrollees, MCOs should encourage out-of-network family planning providers to coordinate services with MCO providers and to educate MCO enrollees to return to MCO providers for continuity of care. If a non-participating provider of family planning services detects a problem outside of the scope of services listed above, the provider must refer the enrollee back to the MCO.

Non-participating providers are responsible for keeping family planning information confidential in favor of the individual patient even if the patient is a minor. The MCO is not responsible for the confidentiality of medical records maintained by non-participating providers.

### ***2.2.7 Maternity Services***

Under the Newborns and Mothers Health Protection Act, the MCO may not:

- Limit benefits for postpartum hospital stays to less than forty-eight (48) hours following a normal vaginal delivery or ninety-six (96) hours following a cesarean section unless the attending provider, in consultation with the mother, makes the decision to discharge the mother or the newborn before that time; or
- Require that a provider obtain authorization from the plan before prescribing this length of stay.

This requirement must not preclude the MCO from requiring prior authorization or denying coverage for elective inductions and elective C-sections.

## **2.3 Medicaid Benefits Covered but Excluded from Capitation that Require Coordination**

Additional services are covered by Medicaid, but excluded from the MCOs' capitation rates. The State will continue to reimburse the billing provider directly for these services on a FFS basis. Please see Appendix A for a complete list of Medicaid-covered services that are excluded from the capitation rates, and additional details regarding these services.

Those Medicaid-covered services that are excluded from the capitation rates (e.g., non-emergency transportation) have particular coordination requirements for MCOs, which are outlined below.

### ***2.3.1 Non-emergency Transportation***

Routine medical transportation to and from Medicaid-covered scheduled medical appointments is covered by the non-emergency medical transportation (NEMT) broker Medicaid program.

This includes transportation via multi-passenger van services and common carriers such as public railways, buses, cabs, airlines, ambulance as appropriate, and private vehicle transportation by individuals. The NEMT broker must approve ambulance, multi-passenger van services, and transportation by common carriers. The MCO must inform enrollees of how to access non-emergency Medicaid transportation as appropriate.

### **2.3.2 Outpatient Pharmacy**

Simple or compound substances prescribed for the cure, mitigation, or prevention of disease or for health maintenance (e.g., prescription drugs, family planning supplies, vitamins for children to age twenty-one (21), and prenatal vitamins) are covered by FFS Medicaid. Hemophilia-related clotting factor drugs, Spinraza, other drugs deemed by DHHR as appropriate for FFS coverage, and Hepatitis-C virus-related drugs will be covered by FFS Medicaid. Drugs and supplies dispensed by a physician, acquired by the physician at no cost, are not covered by Medicaid. The Department will provide the MCO with pharmacy utilization data to support coordination of care for the enrollee.

The MCO remains responsible for all other provider-administered drugs, such as those provided as part of an inpatient stay, a bundled ER visit, or administered vaccinations.

### **2.3.3 Organ and Tissue Transplantations**

MCO enrollees receiving services for transplantation of organs or tissues, other than corneal transplants, are covered under FFS Medicaid for the entire duration of their treatment.

The MCO must have the ability to notify the State of any past, present, or future transplant recipient and request transfer to FFS Medicaid. The Department will coordinate with Utilization Management vendor and MMIS vendor to transition enrollees to the FFS system and coordinate care at that time. The enrollee will be covered under FFS retroactively to the beginning of the month that the MCO notifies the State. Capitation will be recouped for this month. Any claims paid during the month by the MCO may be reversed and directed to the fiscal agent for payment.

## **2.4 Non-covered Services**

MCOs are not permitted to provide Medicaid excluded services that include, but are not limited to, the following:

1. All non-medically necessary services\*;
2. Sterilization of a mentally incompetent or institutionalized individual;
3. Except in an emergency, inpatient hospital tests that are not ordered by the attending physician or other licensed practitioner, acting within the scope of practices, who is responsible for the diagnosis or treatment of a particular patient's condition;
4. All organ transplants, except for those specified in Appendix A;
5. Treatments for infertility<sup>4</sup> and for the reversal of sterilization;

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<sup>4</sup> Infertility services are excluded per West Virginia State law, section 33-25A-4(2)(b).

6. Sex transformation procedures and hormone therapy associated with sex transformation procedures
7. All cosmetic services, except for those provided as a result of accidents or birth defects; and
8. Christian Science nurses and sanitariums.

*\*The above language is not inclusive of children's residential treatment services which is covered using a bundled funding model of Medicaid and ACF funds.*

The MCO must not reimburse for drugs, drug products, and related services, which are defined as a non-covered benefit by the Department's Outpatient Drug Pharmacy Program.

In accordance with 42 U.S.C. § 1396r-8, the MCO must exclude coverage for any drug marketed by a drug company (or labeler) that does not participate in the federal drug rebate program. The MCO is not permitted to provide coverage for any drug product, brand name or generic, legend or non-legend, sold or distributed by a company that did not sign an agreement with the federal government to provide Medicaid rebates for that product.

The MCO must not provide coverage under any circumstances for drug products that have been classified as less-than-effective by the Food and Drug Administration (FDA) Drug Efficacy Study Implementation (DESI).

MCOs cannot enhance the benefits provided to Medicaid enrollees, with the exception of clinical preventive services, without the prior approval of DHHR.

## **2.5 Other Requirements Pertaining to Covered Services**

MCOs must assume responsibility for all covered medical conditions, inclusive of pre-existing conditions of each enrollee as of the effective date of enrollment in the plan. MCOs may not prohibit or otherwise restrict a covered health professional from advising his/her patient about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for that care or treatment are provided under the Contract, if the professional is acting within the lawful scope of practice.<sup>5</sup>

MCOs and their participating providers may not bill or collect any payment from enrollees for a Medicaid service that was determined not to be Medically Necessary or an SNS that was determined not to be Socially Necessary. Anyone who knowingly and willfully charges for any service provided to a patient under a State Plan approved under Title XIX or under a MCO Contract under 1903(m) of the Social Security Act, money or other consideration at a rate in

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<sup>5</sup> The term "health care professional" means a physician (as defined in section 1861(r) of the Social Security Act) or other health care professional if coverage for the professional's services is provided under the Managed Care Plan's Contract for the services. A health care professional includes the following: podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse, registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

excess of the rates established by DHHR or Contract will be guilty of a felony and upon conviction will be fined no more than \$25,000 or imprisoned for no more than five years, or both.

## **2.6 Requirements Pertaining to Medicaid Managed Care Programs**

The MCO must follow the benefit packages and policies of Medicaid managed care programs as required by this Contract and Contract Appendices. The MCO should refer to the FFS Medicaid provider manuals available on the DHHR website for an explanation of service limitations.

### **2.6.1 PCP Responsibilities**

PCPs will be the MCO enrollee's initial and most important contact with the Medicaid MCO. The PCPs' responsibilities are outlined in Article III, Section 3.2 of the contract.

### **2.6.2 Multidisciplinary Teams (MDT)**

An MDT works together with the child in foster care and the child's family to develop a case service plan and coordinate services. It is the central point for decision making during the life of a case. The MCO must participate in the MDT process at the request of the CPS worker, judge, or the MDT itself. The MCO need not participate in every MDT, but is expected to serve as a resource to caseworkers to help in facilitating the process if needed, to ensure the enrollee is receiving the most appropriate, effective treatment options.

## **3. PROVIDER NETWORK**

### **3.1 General Requirements**

#### **3.1.1 Network Capable of Full Array of Services**

The MCO must establish and maintain provider networks in geographically accessible locations for the populations to be served. These networks must be comprised of hospitals, primary care providers (PCPs), dental, specialty care providers, residential treatment providers, and non-traditional providers who provide SNS in sufficient numbers to make available all covered services as required by the availability and access standards of the contract. The MCO must maintain a sufficient number, mix, and geographic distribution of providers.

The MCO must contract with sufficient numbers of providers to maintain sufficient access in accordance with DHHR's Medicaid managed care network standards and SNS provider network standards for all enrollees, including those with limited English proficiency or physical or mental disabilities.

The Provider network must include the following:

- Primary care and specialist providers who are trained or experienced in trauma-informed approach to care and in treating individuals with complex special needs, including all the population which comprises the enrollees covered under this Contract; and
- Providers who have knowledge and experience in identifying child abuse and neglect.

The MCO must submit to the Department written documentation of the adequacy of its provider network as set forth in this Contract at the following times:

- When the MCO enters into a Contract with DHHR;
- On an annual basis;
- When there has been a significant change in MCO operations;
- When services, benefits, geographic service areas, or payments have been changed; or
- When there is enrollment of a new population in the MCO.

The MCO must contract with the full array of providers necessary to deliver a level of care that is at least equal to the community norms and meet the travel time, appointment scheduling, and waiting time standards included in this contract.

The MCO must maintain and monitor a network of appropriate, credentialed providers, supported by written arrangements, that is sufficient to provide adequate access (as defined by DHHR) to covered services (including the appropriate range of preventive, primary care, and specialty services) and to meet the needs of the population served. In establishing and maintaining the network, the MCO must consider the following:

- Anticipated enrollment under this Contract;
- Expected utilization of services, taking into consideration the characteristics and health care needs of the specific populations covered by the MCO;
- Numbers and types (in terms of training, experience, and specialization) of providers required to furnish all contracted services;
- Numbers of network providers who are not accepting new patients; and
- Geographic location of providers and enrollees, considering distance, travel time, the means of transportation ordinarily used by these enrollees, and whether the location provides physical access for enrollees with disabilities.

If the MCO fails to build and/or maintain a provider network that meets the managed care network adequacy standards established by DHHR, or is unable to ensure enrollees' access to the full array of covered services, the MCO will be prohibited from serving enrollees in the deficient geographic areas.

### ***3.1.2 Availability and Access Standards***

The MCO must ensure that all covered services, including additional or supplemental services contracted by or on behalf of Medicaid enrollees, are available and accessible as required in 42 CFR §438.68, §438.206, and §438.207. The MCO must have policies and procedures, including coverage rules, practice guidelines, payment policies and utilization management, that allow for individual medical necessity determinations.

The Department has set minimum provider network adequacy standards that the MCO must meet or exceed in all geographic areas in which the MCO operates. The full list of network adequacy standards is included in Appendix K. They include standards for:

- PCPs’;
- Specialists;
- OB/GYNs;
- Basic hospital services;
- Tertiary hospital services<sup>6</sup>;
- Pediatric dental providers;
- Behavioral Health providers and facilities;
- Substance Use Disorder (SUD) providers and facilities; and
- Additional providers when it promotes the objectives of the Medicaid program as determined by CMS.

The intent of these standards is to provide for access to services at least as good, if not better, than access to care under the traditional Medicaid program. DHHR will periodically publish specific network standards that define which provider types are considered adult and pediatric specialists. The MCO will be required to comply with updated network standards within ninety (90) calendar days of issuance, unless otherwise agreed to in writing by DHHR within sixty (60) calendar days of issuance.

During any period in which the MCO does not meet minimum network standards, the MCO must ensure that appropriate processes are implemented to adequately cover services in a timely manner out-of-network, including paying claims to out-of-network providers and ensuring that enrollees incur no additional costs, as specified in 42 CFR §438.206(b) and §457.1230(a).

#### *3.1.2.1 Exceptions to Network Standards*

The Department will consider requests for exceptions to the provider access standards under limited circumstances (e.g. if no appropriate provider types are located within the mileage standards) and may, in its sole discretion, grant exceptions to these standards. Each exception request from the MCO to the Department must be in writing and supported by information and documentation from the MCO. Exceptions to network requirements will be considered based on the information provided, current patterns of care, and locations where the travel time and distance standards differ significantly from providers in the community.

#### *3.1.2.2 Provider Hours Operation*

The MCO must ensure that the hours of operation of its providers are convenient, do not discriminate against enrollees, and are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid FFS. MCOs must ensure that waiting times at sites of care are kept to a minimum and ensure that the waiting time standard for Medicaid enrollees is the same standard used for commercial enrollees. Providers cannot discriminate against Medicaid

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<sup>6</sup> Tertiary hospital services include (1) acute care services to pediatric patients in medical and surgical units; (2) obstetrics services; and (3) a neo-natal intensive care unit.

enrollees in the order that patients are seen or in the order that appointments are given (providers are not permitted to schedule Medicaid-only days).

When Medically Necessary, the MCO makes services available twenty-four (24) hours a day, seven (7) days a week. The MCO must establish a mechanism to ensure that providers comply with the access standards set forth in this contract. The MCO should regularly measure the extent to which providers in the network comply with these requirements and take remedial action if necessary.

#### *3.1.2.3 Provider Cultural Competency Requirements*

The MCO must ensure that services are provided in a culturally competent manner to all enrollees, including: those with limited English proficiency or reading skills, those with diverse cultural and ethnic backgrounds, the homeless, and individuals with physical and mental disabilities, regardless of gender, sexual orientation, or gender identity. The MCO must also ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.

#### *3.1.2.4 Timeliness of Access to Care*

The MCO must have standards for timeliness of access to care and enrollee services that take into account the urgency of the need for services and that meet or exceed such standards as may be established by DHHR. The MCO must also regularly monitor its provider network's compliance with these standards, and take corrective action as necessary. Current DHHR standards for timeliness state that:

- Emergency cases must be seen immediately or referred to an emergency facility;
- Urgent cases must be seen within forty-eight (48) hours;
- Routine cases other than clinical preventive services, must be seen within twenty-one (21) calendar days (exceptions are permitted at specific times when PCP capacity is temporarily limited);
- EPSDT services must be scheduled in accordance to EPSDT guidelines and the EPSDT Periodicity Schedule;
- An initial prenatal care visit must be scheduled within fourteen (14) calendar days of the date on which the woman is found to be pregnant; and
- MCOs should encourage enrollees with Supplemental Security Income (SSI) to schedule an appointment with a PCP or specialist who manages the enrollee's care within forty-five (45) calendar days of initial enrollment. If requested by the enrollee or provider, the MCO should schedule or facilitate an appointment with the enrollee's PCP.

#### **3.1.3 Specialty Care**

The MCO must provide or arrange for necessary specialty care, including behavioral health services, SUD services, women's health services, and SED services (if applicable). The MCO must allow women direct access to a women's health specialist (e.g., gynecologist, certified nurse midwife) within the network for women's routine and preventive health care services, in

addition to direct access to a PCP for routine services, if the PCP is not a women's health specialist. The MCO should have a policy encouraging provider consideration of beneficiary input in the provider's proposed treatment plan.

#### **3.1.4 Provider Qualification and Selection**

The MCO must implement written policies and procedures for selection and retention of affiliated providers. If such functions are delegated, credentialing and recredentialing policies and procedures must meet the requirements of this section. In contracting with its providers, the MCO must abide by all applicable federal regulations including but not limited to W. Va. C.S.R. §114-53-6 and 42 CFR 438.610 and 42 CFR 455, Subpart B.

For physicians and other licensed health care professionals, including members of physician groups, the process includes:

- Procedures for initial credentialing;
- Procedures for recredentialing at least every three (3) years, recertifying, and/or reappointment of providers;
- A process for receiving advice from contracting health care professionals with respect to criteria for credentialing and recredentialing of individual health care professionals; and
- Written policies and procedures for denying, suspending, or terminating affiliation with a contracting health care professional, including an appeals process, and for reporting serious quality deficiencies to appropriate authorities.

For each institutional provider or supplier, the MCO must determine, and redetermine at specified intervals, that the provider or supplier is licensed to operate in the state, is in compliance with any other applicable state or federal requirements, and is reviewed and approved by an appropriate accrediting body or is determined by the MCO to meet standards established by the MCO itself.

The MCO must submit a report to the Department monthly with the names, National Provider Identifiers (NPIs), and Employer Identification Number (EIN) or Medicaid ID of any health care professional, institutional provider, or supplier that has been the subject of program integrity actions. Actions may include denied credentialing, suspension, termination, CAPs, fines, or sanctions because of concerns about provider fraud, integrity, or quality deficiencies during the prior calendar month. The report must also state the action taken by the MCO (e.g., denied credentialing, education). This information must be reported using the appropriate template created by the Department. Suspensions, terminations, providers denied credentialing, and providers not renewed are reported on the Suspension and Adverse Enrollment Action Report template. Other program integrity actions are reported on the Fraud, Waste, and Abuse (FWA) Monthly Report template. Additional information can be found in Article III, Section 9.1 of this Contract. The MCO must also report any health care-related criminal convictions, when disclosed, to the Department. The MCO must also notify appropriate licensing and/or disciplinary bodies and other appropriate authorities.

The MCO must ensure compliance with Federal requirements prohibiting employment or contracts with individuals excluded from participation under Medicaid, Medicare, or the Children's Health Insurance Program, as required by 42 CFR 438.610. The MCO must provide written disclosure of any prohibited affiliation, as directed in 42 CFR 438.608 (c)(1).

The MCO may not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. This law may not be construed to prohibit the MCO from including providers only to the extent necessary to meet the needs of the MCO's enrollees from using different reimbursement amounts for different specialties or for different practitioners in the same specialty, or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the MCO. If the MCO declines to include providers in its network, the MCO must give the affected providers written notice of the reason for its decision.

The formal selection and retention criteria used by the MCO may not discriminate against health care professionals who serve high-risk populations or who specialize in the treatment of costly conditions.

#### *3.1.4.1 Enrollment with the State*

All network providers that order, refer, or render Medicaid covered services must enroll with the Department, through the fiscal agent, as a Medicaid provider, as required by 42 CFR 438.602(b). Enrollment with the Department does not obligate the MCO provider to offer services under the FFS delivery system. The MCO is not required to contract with a provider enrolled with the Department that does not meet their credentialing or other requirements.

As part of the provider enrollment process, the fiscal agent, on behalf of the Department, will perform monthly federal databases checks as required by 42 CFR 455.436 and share results with the MCO. The MCO must collaborate with the fiscal agent to ensure compliance of all entities per Article II, Section 8.7.

The MCO may execute a provider agreement, pending the outcome of this screening, enrollment, and revalidation, for up to one hundred twenty (120) days. However, the MCO must terminate the network provider immediately upon notification from the state that the network provider cannot be enrolled, or if the one hundred twenty (120) day period expired without state enrollment of the provider. Upon termination of the provider from the MCO's network, the MCO must notify all affected enrollees.

#### **3.1.5 Credentialing and Recredentialing Criteria**

The credentialing process must comply with West Virginia C.S.R. §114-53-6 and 42 CFR 455, Subpart B and at a minimum include a statement by the applicant regarding:

- Any physical or mental health problems that may affect current ability to provide health care;
- Any history of chemical dependency/SUD;
- History of loss of license;

- Felony convictions as required by West Virginia C.S.R. §114-53-6.3 and other criminal convictions as required by 42 CFR 455.106;
- History of loss or limitation of privileges or disciplinary activity;
- History of debarment, suspension or exclusion from any Federal or State healthcare programs; and
- An attestation to correctness/completeness of the application.

During the initial credentialing process, the MCO must verify:

- The identity and the exclusion status of provider and any person with an ownership or control interest or who is an agent or managing employee of the provider through checks of Federal databases as described in 42 CFR 455.436;
- The provider holds a current valid license to practice;
- Valid Drug Enforcement Administration (DEA) or Controlled Dangerous Substance (CDS) certificate, as applicable;
- Graduation from medical school and completion of a residency, or other post-graduate training, as applicable;
- Board certification or eligibility, or specialized training as appropriate;
- Work history;
- Professional liability claims history;
- Good standing of clinical privileges at the hospital designated by the provider as the primary admitting facility (this requirement may be waived for practices which do not have or do not need access to hospitals);
- The provider holds current, adequate malpractice insurance with minimum coverage requirements of \$1 million per individual episode and \$1 million in the aggregate;
- Any revocation or suspension of a state license or DEA/ Bureau of Narcotics and Dangerous Drugs (BNDD) number;
- Any curtailment or suspension of medical staff privileges (other than for incomplete records);
- Any censure by the State or County Medical Association; and
- Any enrollee complaints.

In addition, the MCO must request information on the provider from the National Practitioner Data Bank and appropriate state licensing boards such as the Board of Medicine, Chiropractic Board, Osteopathic Board and/or Dental Board.

During the recredentialing process, the MCO must re-verify and update all of the above information, and consider performance indicators such as those collected through the quality assurance and performance improvement program (see Article III, Section 7 of this contract), the

utilization management system, the grievance system, enrollee satisfaction surveys, enrollee complaints, and other activities of the MCO.

All contracted providers must meet the credentialing and recredentialing requirements listed in this Contract.

### **3.1.6 Additional Credentialing and Recredentialing Criteria for Certain Providers**

#### *3.1.6.1 Credentialing and Recredentialing Criteria for PCPs, OBGYNs, and Other Specialists*

Additional credentialing criteria for PCPs, obstetricians/gynecologists (OBGYNs) and other high-volume specialists must include a visit to the provider's office, documenting a structured review of the site and medical record keeping practices to ensure conformance with the MCO standards. The MCO must maintain a recredentialing policy with all activities continuing to be conducted every three (3) years. Site visits are not required at the time of recredentialing.

#### *2.1.6.2 Credentialing and Recredentialing Criteria for Dental Providers*

Additional credentialing and recredentialing criteria for dental providers must include: Anesthesia permit and/or certificate from the West Virginia Board of Dental Examiners for those dental providers who induce central nervous system anesthesia.

#### *2.1.6.3 Credentialing and Recredentialing Criteria for Behavioral Health Care Providers and Agencies*

Additional credentialing and recredentialing criteria for behavioral health care providers and agencies must include:

- The MCO must verify that a Comprehensive Behavioral Health Center or a Licensed Behavioral Health Center holds a valid license through the West Virginia Office of Health Facility Licensure and Certification;
- The MCO must verify that an independent psychologist or an independent practicing licensed social worker holds current license with their professional boards; and
- The MCOs must verify the MCO physician is approved to provide Suboxone® treatment by the Department. A licensed MCO physician who intends to provide Suboxone® treatment must meet the following requirements:
  1. Physician must qualify for a waiver under the Drug Addiction Treatment ACT (DATA);
  2. Physician must have an assigned DEA (X) number and complete the training regarding Suboxone® treatment guidelines; and
  3. Physician must notify the Center for Substance Abuse Treatment of the intention to treat addiction patients.

### **3.1.7 Provider Education and Training**

The Contractor must provide training to all contracted providers and their staff regarding the requirements of the Contract and special needs of its enrollees. The Contractor must conduct initial training within thirty (30) calendar days of executing a contract with a newly contracted

provider. The Contractor must also conduct ongoing training which may include webinars and web-based tutorials, as deemed necessary by the Contractor or DHHR in order to ensure compliance with program standards and this Contract and meet the needs of providers.

The Contractor must develop and submit the Provider Training Manual and Training Plan, including topics, schedule and languages spoken, to DHHR for initial review and approval at least thirty (30) calendar days prior to any scheduled trainings and as updated thereafter. DHHR may attend any training sessions specific to this Contract at its discretion.

The Contractor must submit to DHHR a provider education and training approach within one hundred fifty (150) calendar days of the Operational Start Date. DHHR must have at least ten (10) calendar days to review the materials and the Contractor must have five (5) calendar days from the completion of DHHR's review to submit the finalized materials to DHHR.

The provider education and training must include, at a minimum:

- The roles and responsibilities of the provider, DHHR, BCF, local CPS workers, enrollees, foster care parents, and adoptive parents with regard to the program and how these partners will coordinate services with the Contractor;
- Covered medical, behavioral, SED waiver and SNS services and the provider's responsibilities for providing and/or coordinating such services. A special emphasis should be placed on areas that vary from MHT and WVHB Medicaid coverage and commercial coverage rules;
- Requirements for providing services to enrollees, including: medical consent requirements, required timelines for services and assessments, special medical information needed for children in Foster Care, appropriate utilization of psychotropic medications;
- Training in a Trauma-Informed Approach to care;
- Information on the effect of abuse and neglect on the developing brain;
- Information on the effect of intrauterine assault, fetal alcohol syndrome and shaken baby syndrome;
- Training in how to screen for and identify trauma, and Behavioral Health and Substance Use Disorders; and
- Training on the Contractor's authorization and referral processes.

### **3.1.8 Service Area**

The MCO must notify DHHR ninety (90) calendar days prior to the desired effective date if it plans to terminate performance of work under this Contract in any service area(s). If the MCO terminates services to any service area(s), the MCO contract must be voided, as statewide coverage at all times is a required condition of the contract.

### **3.1.8 Network Changes**

In addition to reporting quarterly on the size and composition of its provider networks, the MCO must notify DHHR of any changes to the composition of its provider network that materially

affect the MCO's ability to deliver all capitated services within seven (7) calendar days of such change identified. The MCO must provide DHHR with advanced written notice of any PCP network deletions within seven (7) calendar days. The MCO must report any disenrollment of hospitals from the MCO's network to DHHR immediately.

In cases of PCP withdrawals, the MCO must also provide enrollees or his representative with at least a thirty (30) day notice whenever possible and allow them the opportunity to select a new PCP before being assigned one. In cases of MCO-initiated provider termination, the MCO must provide written notice to enrollees when a contracted provider has been terminated, within fifteen (15) calendar days of issuance of the termination notice. The MCO must have procedures to address changes in its network that constrain the ability of clients to access services. The Contractor must notify DHHR within seven (7) business days of any significant changes to the provider network or, if applicable, to any subcontractors' provider networks. Material changes in network composition that negatively affect client access to services and which are not corrected may be grounds for Contract termination.

## **3.2 Primary Care Providers (PCPs)**

### ***3.2.1 PCP Responsibilities***

The PCP will be the MCO enrollee's initial and most important contact with the MCO. As such, PCPs must have at least the following responsibilities:

- Maintaining continuity of each enrollee's health care by serving as the enrollee's primary care provider;
- Providing twenty-four (24) hour, seven (7)-day-a-week access;
- Making referrals for specialty care and other Medically Necessary covered services, both in-network and out-of-network, consistent with the MCO's utilization management policies;
- Maintaining a current medical record for the enrollee, including documentation of all services provided to the enrollee by the PCP, as well as any specialty or referral services;
- Adhering to the EPSDT Periodicity Schedule for enrollees under age twenty-one (21); and
- Following MCO-established procedures for coordination of in-network and out-of-network services for Medicaid enrollees.

Although PCPs must be given responsibility for the above activities, the MCO must also retain responsibility for monitoring PCP actions to ensure they comply with MCO and West Virginia Medicaid managed care program policies.

Additionally, the MCO must communicate with PCPs about the delivery of primary behavioral health services within their scope of practice, as well as the appropriate circumstances for making referrals to behavioral health providers. MCOs may provide this information through its provider manual, continuing education agendas, informal visits by provider representatives, or any other means. The MCO must ensure that PCPs are successfully identifying and referring

patients to a behavioral health provider and provide education to PCPs who do not have training in this area.

### **3.2.2 Ratio of PCPs to Enrollees**

The MCO's provider network must include a panel of primary care providers (PCPs) from which the enrollee may select a personal PCP. The MCO must maintain an adequate panel of available PCPs so that the ratio of PCPs to enrollees meets or exceeds the required ratio of one (1) PCP for every five hundred (500) adult enrollees who is accepting new enrollees and one (1) age appropriate PCP for every two hundred fifty (250) pediatric enrollees under twenty-one (21) who is accepting new patients as outlined in Appendix K.

Only PCPs who have assigned MCO enrollees and are listed in the MCO's provider directory as accepting new patients will count toward the provider-to-enrollee ratio. Specialists designated as PCPs for certain individuals will not count toward the standard, unless these providers are willing to serve as the PCP for other enrollees. The provider-to-enrollee ratio is distinct from the requirement in the MCO contract regarding the total assigned panel size for any individual PCP.

#### **3.2.2.1 PCP Enrollee Panels**

The MCO is expected to ensure that the Medicaid enrollee panel of any PCP in its network does not exceed two thousand (2,000) Medicaid enrollees. The two thousand (2,000) Medicaid enrollee limit applies to each PCP. In the case of PCP teams (see below), this ratio may be adjusted. Exceptions to this limit may be made with the consent of the physician and DHHR. Reasons for exceeding the limit may include: continuation of established care; assignment of a family unit; availability of mid-level clinicians in the practice that effectively expand the capacity of the physician; and inadequate numbers of providers in the geographic area.

Recognizing that precise numerical ratios are not readily enforceable, the MCO must take measures to ensure compliance with this requirement such as monitoring PCPs' panels and enrollees' access to PCPs. DHHR will monitor PCP panels across MCOs and notify each affected MCO if the total Medicaid enrollee panel of a PCP in its network exceeds two thousand (2,000) Medicaid enrollees. MCOs must reduce the caseload for PCPs with panels above two thousand (2,000) Medicaid enrollees across the program unless one (1) of the exceptions above is granted.

### **3.2.3 Assignment of PCP**

The MCO must have written policies and procedures for assigning each of its enrollees to a PCP. The MCO will assume responsibility for assisting the enrollee with PCP selection. MCOs must make a PCP assignment within five (5) calendar days after a Medicaid beneficiary is enrolled in the MCO. The process whereby MCOs assign PCPs to enrollees must take into consideration such known factors as current provider relationships, age, the child's placement (physical location), claims history, and input by DHHR caseworker. The MCO then must notify the enrollee or his representative in writing of his or her PCP's name, location and office telephone number, and the process for selecting a new PCP if the enrollee so desires.

Enrollees with a disabling condition, chronic illness or who are SSI eligibles, must have a choice of specialist physician to serve as their PCP. The specialist physician must agree to perform all

PCP duties required in the Contract and the PCP duties must be within the scope of the specialist's license.

### **3.2.4 Types of Primary Care Providers (PCPs)**

The MCO is required to contract with a mix of PCPs to ensure the primary care needs of all enrollees are met. The MCO may designate the following providers as PCPs, as appropriate:

- Certified nurse midwives<sup>7</sup>;
- Advanced practice nurses (e.g. nurse practitioners (NP)<sup>8</sup>);
- Physician assistants; and
- Physicians with the following specialties: General practice; Family practice; Internal medicine; Obstetrics/Gynecology; and Pediatrics.

The MCO will be allowed to designate physicians outside of these specialties as PCPs for specific individuals including those within the disabled population whose underlying health conditions are best managed by specialists.

The MCO must permit any certified nurse midwife, advanced practice nurse or PA, who is otherwise permitted within the scope of their practice, and who is a Medicaid enrolled provider, to be designated a PCP for an enrollee and bill independently.

### **3.2.5 PCP Team in Teaching Settings**

If the MCO's primary care network includes institutions with teaching programs, PCP teams, comprised of residents, physicians' assistants and a supervising faculty physician, may serve as a PCP. The MCO must organize its PCP teams so as to ensure continuity of care for enrollees and must identify a lead physician within the team for each enrollee. The lead physician must be an attending physician and not a resident.

### **3.2.6 PCP Transfers**

The MCO must have written policies and procedures for allowing Medicaid enrollees to select or be assigned to a new PCP when such a change is requested by the enrollee, when a primary care provider is terminated from the MCO, or when a PCP change is ordered as part of the resolution to a formal grievance proceeding. In cases where a PCP has been terminated, the MCO must allow affected enrollees to select other PCPs or make a reassignment within fifteen (15) calendar days of the termination effective date.

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<sup>7</sup> Certified nurse midwives are required to practice in a collaborative relationship with a licensed physician (West Virginia Code §30-15-7). The MCO must ensure compliance with all relevant federal and state regulations related to certified nurse midwives.

<sup>8</sup> Nurse practitioners with prescriptive authority must practice in a collaborative relationship with a licensed physician (West Virginia Code §30-7-15a). The MCO must ensure compliance with all relevant federal and state regulations related to nurse practitioners.

Enrollees may initiate a PCP change at any time, for any reason. The request can be made in writing or over the phone. MCOs are permitted to limit PCP changes to one time per month. The MCO may initiate a PCP change for a Medicaid enrollee under the following circumstances:

1. The enrollee moves or there is a change in the placement of a child in foster care and the assigned PCP location no longer meets the access standards;
2. The enrollee requires specialized care for an acute or chronic condition, and the enrollee and MCO agree that reassignment to a different PCP is in the enrollee's interest;
3. The enrollee's PCP ceases to participate in the MCO's network;
4. The enrollee's behavior toward the PCP is disruptive, and the PCP has made all reasonable efforts (three (3) attempts within ninety (90) calendar days) to accommodate the enrollee; or
5. The enrollee has taken legal actions against the PCP.

### ***3.2.7 PCP Panel Monitoring***

The MCO must maintain written policies and procedures for monitoring participating PCP panel status and capacity. At a minimum, MCO policies and procedures must capture PCP panel capacity monitoring, PCP notifications of its panel size, changes in the PCP panel status, and limits.

The MCO must furnish each PCP with a current list of enrollees assigned to that provider no later than five (5) business days after the end of each month, unless the PCP agreed to an alternative schedule. The MCO may offer and provide such information in alternative formats, such as through access to a secure internet site, when such format is acceptable to the PCP.

The MCO must have a process in place to allow for enrollee reassignment upon PCP request if the enrollee falls outside the provider's provider type.

### **3.3 Specialty Care Providers, Hospitals and Other Providers**

The MCO must Contract with a sufficient number and mix of specialists and hospitals so that the enrolled population's anticipated specialty and inpatient care needs can be substantially met within the MCO's network of providers. The MCO must also have a system to refer enrollees to out-of-network providers if appropriate participating providers are not available.

The MCO must make referrals available to enrollees when it is medically appropriate. The MCO must have policies and written procedures for the coordination of care and the arrangement, tracking, and documentation of all referrals.

Medicaid enrollees of the MCO must have access to certified pediatric or family NPs and certified nurse midwives, even if such providers are not designated as PCPs.<sup>9</sup> MCOs must Contract with these providers to the extent practical.

### **3.4 Publicly Supported Providers**

#### **3.4.1 Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)**

Federally Qualified Health Centers (FQHCs) are federally-funded Community Health Centers, Migrant Health Centers and Health Care for the Homeless Projects that receive grants under sections 329, 330 and 340 of the US Public Health Service Act.<sup>10</sup> Current federal regulations specify that states must guarantee access to FQHCs and RHCs under Medicaid managed care programs; therefore, MCOs must provide access to FQHCs and RHCs to the extent that access is required under federal law. If federal law is amended to revise these access requirements, DHHR may alter the requirements imposed on MCOs.

The MCO must Contract with as many FQHCs and RHCs as necessary to permit beneficiary access to participating FQHCs and RHCs without having to travel a significantly greater distance past a non-participating FQHC or RHC. The MCO must Contract with the FQHC or RHC – contracts with individual physicians at FQHCs and RHCs do not suffice for this requirement. The MCO must Contract with FQHCs and RHCs in accordance with the time and distance standards for routinely-used delivery sites as specified in this contract in Appendix K. An MCO with an FQHC or RHC on its panel that has no capacity to accept new patients will not satisfy these requirements. If an MCO cannot satisfy the standard for FQHC and RHC access at any time while the MCO holds a Medicaid contract, the MCO must allow its Medicaid enrollees to seek care from non-contracting FQHCs and RHCs and must reimburse these providers at Medicaid fees.

The MCO must offer FQHCs and RHCs terms and conditions, including reimbursement, which are at least equal to those offered to other providers of comparable services. The MCO cannot sign exclusive contracts with any publicly supported providers that prevent the providers from signing contracts with other MCOs. Upon DHHR notification to the MCO of any changes to the FQHC/RHC reimbursement rates, the MCO must update payment rates to FQHC/RHCs to the effective date in the notification by DHHR. The MCO must pay the new rate for any claims not yet paid with a date of service on or after the effective date of change. If payment has already been made for a claim within SFY 2020 with a date of service on or after the effective date of the rate change, the MCO must reprocess the claim to reimburse at the new rate. The new payment rate must be loaded into the MCO's claims payment system within thirty (30) calendar days of notification of the payment rate change.

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<sup>9</sup> Since federal law requires states to assure access to certified pediatric or family nurse practitioners and certified nurse midwives, and states are not allowed to waive this requirement, the MCOs must provide access to these services.

<sup>10</sup> Health centers not receiving grants but certified by the Secretary of Health and Human Services as meeting the requirements of the grant program may also apply for FQHC status as an FQHC “look-alike.” All FQHCs are non-profit or public entities and must be located in areas designated by the federal government as medically underserved.

### **3.4.2 Local Health Departments**

Local governmental departments administer certain public health programs which are critical to the protection of the public's health and, therefore, must be available to Medicaid managed care enrollees. For those services defined as public health services under State law, the MCO may choose either to provide these services itself or to Contract with local health departments. However, if an MCO enrollee seeks such a service directly from a non-contracted local health department, the MCO must pay for the service at the lesser of the health department's fee rate or the Medicaid fee rate.

The MCO must provide the following core services to Medicaid managed care enrollees and must reimburse the local health departments as specified:

1. All sexually transmitted disease services including screening, diagnosis, and treatment;
2. Human immunodeficiency virus (HIV) services including screening and diagnostic studies;
3. Tuberculosis services including screening, diagnosis, and treatment; and
4. Childhood immunizations. The MCO must obtain vaccines from the State Bureau for Public Health's Immunization Program. Any time an MCO enrollee seeks immunizations from a governmental public health entity, the MCO must pay for such services at current Medicaid FFS rates for administration costs only. For Medically Necessary situations, non-Vaccines For Children (VFC) vaccines administered by governmental public health entities to MCO clients, the MCO must reimburse for the cost of the vaccines. MCOs should encourage providers to refer their patients to these programs.

Environmental lead assessments for MCO children with elevated blood levels will be reimbursed directly by the State Bureau for Public Health. The MCO is responsible for the blood lead screenings.

The MCO must work with the local health departments to coordinate the provision of the above services and to avoid duplication of services.

Local Health Departments (LHD) providing Medicaid services must have the right to participate in the MCO network, so long as such providers comply with the terms and conditions of the MCO provider Contract and provider qualification and credentialing process.

### **3.4.3 Critical Access Hospitals (CAH)**

The MCO is encouraged, but not required, to Contract with Critical Access Hospitals (CAH) for inpatient and outpatient hospital services.

### **3.4.4 Primary Care Centers**

The MCO is encouraged, but not required, to Contract with state-designated primary care centers to provide services.

### **3.4.5 School-Based Health Centers**

School-based health centers (SBHCs) provide general, primary health care services to school-aged children. The State recognizes these centers as increasingly important providers of primary

health care, especially in rural communities which face shortages of primary care physicians. DHHR encourages the MCO to Contract with or develop cooperative agreements with SBHCs. Such agreements would recognize the MCO as the medical home for the child, define the process for referring students to MCO network providers, spell out procedures for sharing medical information between the SBHCs and the MCO, and provide for reimbursement of the SBHC by the MCO.

The MCO is encouraged, but not required, to Contract with SBHCs.

#### ***3.4.6 Right from the Start (RFTS) Providers***

Right from the Start (RFTS) is a West Virginia State program aimed at improving early access to prenatal care and lowering infant mortality, and improved pregnancy outcomes. The RFTS eligibility criteria and services provided are available from DHHR.

The MCO is encouraged, but not required, to contract with RFTS providers. However, if the MCO does not contract with RFTS providers, the MCO must provide the same level and types of services as those currently available through the RFTS program. This includes access to multidisciplinary care. DHHR will monitor compliance with this requirement; if the MCO fails to satisfy these requirements, it will be required to reimburse the traditional Right from the Start providers at the Medicaid fee rate. The MCO may not place prior authorization requirements on RFTS services.

#### ***3.4.7 Bureau for Public Health Laboratories***

The MCO is required by law to use Bureau for Public Health Laboratories for certain cases (e.g., metabolic testing for newborns, rabies), and the Bureau for Public Health Laboratories is required to perform tests, including those mentioned under core services above, on MCO enrollees for public health purposes. In addition, all laboratories contracted by MCOs who have positive findings of certain reportable diseases under the Reportable Disease Rule in category I, II and IV (the list of reportable diseases is available from DHHR) must submit an isolate, serum specimen or other designated material to the Office of Laboratory Services (OLS) for confirmation or other testing needed for epidemiological surveillance. These services are usually funded by state or federal funds; however, whenever a service is not funded by other state or federal funds, the MCO must reimburse OLS for these services.

#### ***3.4.8 Children with Special Health Care Needs Program (CSHCN) Providers***

The Children with Special Health Care Needs (CSHCN) Program provides care coordination and access to specialty services through a system of community-based Care Coordinators<sup>11</sup> and specialty clinics, thus enabling children and youth with special health care needs to receive a patient/family-centered medical home approach to comprehensive, coordinated services and supports.

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<sup>11</sup> Registered Nurses and Licensed Social Workers that, on behalf of medical homes of children and youth with special health care needs, facilitate the patient and family engagement necessary for coordinated, ongoing, comprehensive care.

The MCO is encouraged, but not required, to contract with CSHCN providers. However, if the MCO does not contract with CSHCN providers, the MCO must provide the same level and types of services as those currently available through the CSHCN program. This includes access to multidisciplinary care. The CSHCN eligibility criteria and services are available from DHHR. DHHR will monitor compliance with this requirement; if the MCO fails to satisfy these requirements, it will be required to reimburse the traditional CSHCN providers at the Medicaid fee rate.

#### **3.4.9 Indian Health Providers**

The MCO must follow the requirements related to Indians, Indian Health Care Providers, and Indian Managed Care Entities in accordance with the terms of 42 CFR 438.14.

### **3.5 Mainstreaming**

The State considers mainstreaming of Medicaid beneficiaries into the broader health delivery system to be important. The MCO must accept responsibility for ensuring that network providers do not intentionally segregate Medicaid enrollees in any way from other persons receiving services. Examples of prohibited practices include, but are not limited to, the following:

1. Denying or not providing to an enrollee any covered service or availability of a facility;
2. Providing to an enrollee any covered service which is different, or is provided in a different manner or at a different time from that provided to other enrollees, other public or private patients or the public at large;
3. Subjecting an enrollee to segregation or separate treatment in any manner related to the receipt of any covered service; and
4. Assigning times or places for the provision of services on the basis of the race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual preference, income status, program membership or physical or mental disability of the participants to be served.

PCPs will not be permitted to close their panels to Medicaid enrollees alone. If a PCP's panel is closed, it must be closed to all enrollees. Should a panel reopen, it will be required to admit patients on a first come, first served basis. However, if a PCP has the maximum of two thousand (2,000) Medicaid enrollees, the PCP may admit additional, non-Medicaid patients.

### **3.6 Provider Services**

#### **3.6.1 Provider Services Department**

The MCO must maintain a Provider Services Department and operate a toll-free provider phone line for at least eight (8) hours a day during regular business hours.

##### *3.6.1.1 Responsibilities of the MCO Provider Services Department*

The Provider Services Department is responsible for the following, but not limited to:

1. Assisting providers with questions concerning enrollee eligibility status;
2. Assisting providers with plan prior authorization and referral procedures;
3. Assisting providers with claims payment procedures;

4. Handling provider complaints;
5. Providing and encouraging training to providers to promote sensitivity to the special needs of this population;
6. Educating providers on the Specialized Managed Care Plan for Children and Youth program; and
7. Educating providers about the MCO's written policies on the False Claims Act, including policies and procedures for detecting and preventing waste, fraud, and abuse. This requirement is pursuant to the Deficit Reduction Act of 2005, Section 6032.

The MCO must ensure that after regular business hours the line is answered by an automated system with the capability to provide callers with operating hours, information and instructions on how to verify enrollment for an enrollee with an Urgent Condition or an Emergency Medical Condition.

#### *3.6.1.2 Performance Requirements of the Toll-Free Provider Phone Line*

The MCO must ensure that the toll-free provider phone line meets the following minimum Service Level Agreements (SLAs):

1. Eighty-three percent (83%) of calls are answered live within thirty (30) seconds during operating hours. Time measured begins when the provider is placed in the call queue to wait to speak to a Provider Services representative; and
2. The call abandonment rate does not exceed five percent (5%) of total calls for the month.

If the MCO's Subcontractor operates a separate call center, the Subcontractor's call center must at a minimum meet the provider phone line performance standards set forth in this Section. Failure by the MCO to ensure the provider call center meets the SLAs above shall result in a penalty of \$5,000 per month for each SLA as outlined in Appendix F.

#### **3.6.2 Provider Manual**

The MCO must develop, distribute and maintain a provider manual. The MCO must submit a copy of the provider manual to DHHR as part of the MCO's initial readiness review during implementation and annually by July 1<sup>st</sup> of each Contract year. In addition, the MCO must document the approval of the provider manual by the MCO Administrator and Medical Director and must maintain documentation that verifies that the provider manual is reviewed at least annually. The MCO must ensure that each provider (individual or group which submits claim and encounter data) is issued a printed or electronic copy of the provider manual during the contracting process with the MCO. The MCO must provide a copy of the provider manual to a provider upon request. When there are Department policy or program changes or MCO procedure or service site changes, notification must be sent to the affected providers at least thirty (30) calendar days before the intended effective date of the change. The MCO must publish and keep current its provider manual on the MCO website.

#### **3.6.3 Provider Contract**

The MCO's provider contracts and addenda to provider contracts must abide by all federal regulations and must be consistent with the requirements of this statement of work. The MCO

must also comply with the prohibitions on inappropriate provider incentives as specified in Article III, Section 3.8 of this contract.

The Department will provide two (2) model provider contracts. One will be tailored to use with Medicaid service providers and the other will be tailored to use with SNS providers. The MCO must resubmit the revised model provider contracts to the Department any time it makes substantive modifications to such agreements.

#### *3.6.3.1 Medicaid Provider Contract*

At a minimum the MCO's Medicaid provider contracts and addenda must include the following provisions:

1. Enrollees will be held harmless for the costs of all Medicaid-covered services provided except for applicable cost-sharing obligations. The Contract must state that the providers must inform enrollees of the costs for non-covered services prior to rendering such services. The provider Contract must state that the MCO's enrollees may not be held liable for the MCO's debts in the event of the MCO's insolvency; providers may not balance-bill.
2. Physicians will maintain adequate malpractice insurance with minimum coverage requirements of \$1 million per individual episode and \$1 million in the aggregate;
3. Reimbursement terms: The Contract must provide a complete description of the payment method or payment amounts applicable to a provider. The MCO provider Contract or provider manual must explain to providers how to submit a clean claim including a complete listing of all required information, including claims coding and processing guidelines for the applicable provider type. The MCO must pay both in-network and out-of-network providers within thirty (30) calendar days of clean claims receipt. The MCO provider must understand and agree that DHHR is not liable or responsible for payment for covered services rendered pursuant to the MCO provider contract;
4. Requirement that providers attest to the following certification for claims for Medicaid goods and services. The certification should include the following information: All statements are true, accurate, and complete; no material fact has been omitted; all services will be medically necessary to the health of the specific patient; and understanding that payment will be from Federal and State funds and that any falsification or concealment of a material fact may be prosecuted under Federal and State law
5. Clear definition of each party's termination options;
6. Requirements for provider disclosure of ownership and control, in accordance with 42 CFR 455.104. The MCO provider contracts must include language defining ownership per 42 CFR 455.101. The MCO provider contracts or disclosure forms must request the provider to disclose information on ownership and control, and information on interlocking relationships per 42 CFR 104 b (3). A provider that is a business entity, corporation, or a partnership must disclose the name, date of birth (DOB), SSN, and address of each person who is provider's director, officer, principal, partner, agent, managing employee, or other person with ownership or control interest of five percent (5%) or more in the provider or in the provider's Subcontractor. The address for corporate entities must include as applicable: primary business address, every business location, P.O. Box address, and tax

ID. Contracts or disclosure forms must solicit information on interrelationships of persons disclosed per 42 CFR 455.104 (b). MCO contracts or disclosure forms must request tax ID of any provider's Subcontractor in which the provider (if entity) has a five percent (5%) or more interest. The MCO provider contracts must request the name of each entity in which the provider's persons with ownership and control interest have an ownership or control interest. The provider must agree to keep information current at all times by informing the MCO in writing within thirty-five (35) calendar days of any ownership and control changes to the information contained in its application;

7. Requirements for provider disclosure of significant business transactions, in accordance with 42 CFR 455.105. MCO provider contracts must include language specifying that the contracted provider is required to disclose the following information related to business transactions within thirty-five (35) calendar days of request of the Secretary of DHHS: full and complete information about (1) the ownership of any Subcontractor with whom the provider has had business transactions totaling more than \$25,000 during the previous 12-month period and (2) any significant business transactions between the provider and any wholly owned supplier, or between the provider and any Subcontractor, during the previous five years;
8. Requirements for provider disclosure of health-care related criminal convictions, in accordance with 42 CFR 455.106. The provider contracts or disclosure forms must request the provider, provider's director, officer, principal, partner, agent, managing employee, or other person with ownership or control interest of five percent (5%) or more in the provider to disclose information on criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on request. The contracts must require a provider to notify the MCO immediately of the time the provider receives notice of such conviction. The MCO must include the definition of "Convicted" per 42 CFR 1001.2 in the Contract or disclosure form;
9. Requirements for providers to report to the MCO provider-preventable conditions associated with claims;
10. Certification that the provider, provider's director, officer, principal, partner, managing employee, or other person with ownership or control interest of five percent (5%) or more in the provider have not been excluded, suspended, debarred, revoked, or any other synonymous action from participation in any program under Title XVIII (Medicare), Title XIX (Medicaid), or under the provisions of Executive Order 12549, relating to federal agreement. Certification that persons listed above have also not been excluded, suspended, debarred, revoked, or any other synonymous action from participation in any other state or federal health-care program. Requirement for a provider to notify the MCO immediately of the time it receives notice that any action is being taken against a provider or any person above as defined under the provisions of Section 1128(A) or (B) of the Social Security Act (42 USC §1320a-7), which could result in exclusion from the Medicaid program. A provider must agree to fully comply at all times with the requirements of 45 CFR Part 76, relating to eligibility for federal agreements and grants;
11. Requirements for access to provider records. The provider contracts must include a provision requiring MCO providers to provide to DHHR: 1. all information required under

the MCO's managed care Contract with DHHR, including but not limited to the reporting requirements and other information related to the network providers' performance of its obligations under the MCO provider contracts; and 2. any information in its possession sufficient to permit DHHR to comply with the federal Balanced Budget Act of 1997 or other federal or state laws, rules, and regulations. MCO provider contracts must include a provision explaining that, if the network provider places required records in another legal entity's records, such as a hospital, the network provider is responsible for obtaining a copy of these records for use by the above named entities or their representative;

12. Requirement for providers to comply with 42 CFR 438.104. The Contract must prohibit providers from engaging in direct marketing to enrollees that is designed to increase enrollment in a particular MCO. The prohibition should not constrain providers from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance;
13. Requirement to comply with Section 6032 of the Deficit Reduction Act of 2005, if the network provider receives annual Medicaid payments of at least \$5 million (cumulative, from all sources). A provider must: 1. Establish written policies for all employees, managers, officers, contractors, Subcontractors, and agents of the network provider. The policies must provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A). 2. Include as part of such written policies detailed provisions regarding the network provider's policies and procedures for detecting and preventing FWA. 3. Include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68)(A), the rights of employees to be protected as whistleblowers, and the provider's policies and procedures for detecting and preventing FWA;
14. Requirement to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191), and the Health Information Technology for Economic and Clinical Health Act (HITECH Act) at 42 U.S.C. 17931 et.seq. The Contract must explain that the provider must treat all information that is obtained through the performance of the services included in the provider Contract as confidential information to the extent that confidential treatment is provided under state and federal laws, rules, and regulations. This includes, but is not limited to, information relating to applicants or enrollees of DHHR programs.
15. Requirement that provider may not interfere with or place any liens upon the State's right or the MCO's right, acting as the State's agent, to recovery from third party resources;
16. Requirement for provider to comply with 42 CFR 422.128 and West Virginia Health Care Decisions Act relating to advance directives;
17. Description of the MCO's provider complaint and appeal processes. The processes must comply with the requirements of this Contract, 42 CFR 438.414, and must be the same for all providers;
18. The provider Contract must prohibit providers from collecting copays for missed appointments;

19. The provider Contract must require emergency care providers to educate the enrollee of the amount of his or her copay for non-emergency services provided in the emergency department prior to providing non-emergency services. The emergency services provider must be required to provide an enrollee with the name and location of an available and accessible alternative non-emergency services provider;
20. Requirement for provider reporting and return of overpayments as outlined in Article III, section 9.3;
21. Notice to the provider of the State's right to collect MCO overpayments directly from the provider pursuant to the MCO's assignment of rights to the Department, as described in Article III, Section 9.3 of the contract between the MCO and the State.
22. Notice to the provider that in the event the State collects overpayments directly from the provider, the provider's appeal rights are outlined in the BMS policy manual Chapter 800(B), which can be found on the BMS website; and
23. Contracts with primary care providers (PCPs) must also include a requirement that the provider have twenty-four (24)-hour physician coverage.
24. The provider contract must identify the specific requirements of the provider in meeting compliance standards for the State's SED waiver. Only those contracts with SED providers need to make reference to these standards, as defined within the SED Waiver Incident Reporting Guide, SED Waiver, and SED Policy Chapter 502.
25. For SED waiver provider contracts, the MCO shall include reference to the Person-Centered Service Plan requirement of the provider for submission to the MCO.

#### ***3.6.4 Provider Information Systems Support***

The MCO must work with providers to establish electronic billing, authorization and reporting systems that are compatible with provider electronic health record (EHR) systems. The MCO's hardware, software, and communications must be capable of accommodating individual provider information systems. Such accommodations may not be in violation any requirements promulgated pursuant to Health Insurance Portability and Accountability Act of 1996, P.L. 104-191 (August 21, 1996), as amended or modified, Health Information Technology for Economic and Clinical Health Act (HITECH Act), and other applicable federal and state laws.

#### ***3.6.5 Provider Satisfaction Survey***

The MCO is required to design, develop, and implement an annual provider satisfaction survey to evaluate provider or provider staff satisfaction with the MCO.

The MCO must collect, analyze, and submit provider survey results to the Department on an annual basis. The survey must be submitted to prior to the conclusion of the contracting period of each Contract year, June 30<sup>th</sup>.

### **3.7 Provider Reimbursement**

#### **3.7.1 General**

The Department believes that one of the advantages of a managed care system is that it permits MCOs and providers to enter into creative payment arrangements intended to encourage and reward effective utilization management and quality of care. The Department therefore intends to give MCOs and providers as much freedom as possible to negotiate mutually acceptable payment terms. However, reimbursement rate amounts over 102.5% of the Medicaid FFS rates are not included in data as part of rate setting to develop the PMPM capitation payment for the MCO.

Regardless of the specific arrangements the MCO makes with providers, the MCO must make timely payments to both its contracted and non-contracted providers, subject to the conditions described below. This includes making a full payment rather than installment payments for a course of treatment if FFS reimburses the entire cost of the treatment at the initiation of service. Additionally, the MCO must accept electronic claims as well as paper claims from providers. The MCO must accept Medicaid claims submitted using the enrollee's Medical Assistance ID (MAID). The MCO must also require all Medicaid claims for payment for items or services that were ordered to contain the NPI of the physician or other professional who ordered or referred such items or services.

The MCO may not seek recoupment of any provider payments beyond twenty-four (24) months from the date of service unless such recoupment is due to provider fraud, waste or abuse.

#### **3.7.2 In-Network Services**

Subject to Article III, Section 3.7, Timely Payment Requirement, the MCO must make timely payment within thirty (30) calendar days for clean claims to in-network providers for Medically Necessary, covered Contract services when:

1. Services were rendered to treat a medical emergency;
2. Services were rendered under the terms of the MCO's Contract with the provider;
3. Services were prior authorized; or
4. Retro-authorization meeting medical necessity has been granted due to the nature of service.

#### **3.7.3 Out-of-Network Services**

Subject to Article III, Section 3.7, Timely Payment Requirement, the MCO must make timely payments within thirty (30) calendar days for clean claims to out-of-network providers for Medically Necessary, covered services when:

1. Services were rendered to treat a Medical Emergency;
2. Services were for family planning and sexually transmitted diseases;
3. Services were prior authorized; or

4. Retro-authorization meeting medical necessity has been granted due to the nature of service.

For non-emergency out-of-network services, the MCO may reimburse providers at eighty (80) percent of the prevailing Medicaid FFS rate or higher, unless such services are deemed medically unnecessary, are not covered by the MCO, or do not receive authorization.

Consistent with Article III, Section 2.2.2, reimbursement for emergency services provided out-of-network must be equal to the Medicaid prevailing FFS reimbursement level for emergency services, less any payments for direct costs of medical education and direct costs of graduate medical education included in the FFS reimbursement rate.

#### **3.7.4 Out-of-Network Hospital Transfers**

The MCO must pay an enrollee's existing out-of-network hospital fees for Medically Necessary covered emergency services until the enrollee's records, clinical information and care can be transferred to a network hospital, or until such time as the enrollee is no longer enrolled in that MCO, whichever is shorter. The MCO must accept the out-of-network hospital physician or provider's binding determination of when the enrollee is sufficiently stabilized for transfer or discharge.

#### **3.7.5 Emergency Services**

When emergency services are provided to an enrollee of the MCO, the MCO's liability for payment is determined as follows:

1. **Presence of a Clinical Emergency:** If the screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition exists, the MCO must pay for both the services involved in the screening examination and the services required to stabilize the patient.
2. **Emergency Services Continue Until the Patient Can be Safely Discharged or Transferred:** The MCO is required to pay for all emergency services which are Medically Necessary until the clinical emergency is stabilized. This includes all treatment that may be necessary to assure, within reasonable medical probability, that no material deterioration of the patient's condition is likely to result from, or occur during, discharge of the patient or transfer of the patient to another facility. If there is a disagreement between a hospital and the MCO concerning whether the patient is stable enough for discharge or transfer, or whether the medical benefits of an unstabilized transfer outweigh the risks, the judgment of the attending physician(s) actually caring for the enrollee at the treating facility prevails and is binding on the MCO. The MCO may establish arrangements with hospitals whereby the MCO may send one of its own physicians with appropriate Emergency Room privileges to assume the attending physician's responsibilities to stabilize, treat, and transfer the patient.
3. **Subsequent Screening and Treatment:** An enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition.
4. **Notification of Enrollee's PCP:** The MCO may not refuse to cover emergency services solely based on the emergency room provider or hospital not notifying the enrollee's

primary care provider, MCO, or DHHR of the enrollee's screening and treatment within ten (10) calendar days of presentation for emergency services. Nothing in this provision precludes the MCO from complying with all other emergency service claims payment requirements as set forth in this contract.

5. **Absence of a Clinical Emergency:** If the screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition does not exist, then the determining factor for payment liability should be whether the enrollee had acute symptoms of sufficient severity at the time of presentation. In these cases, the MCO must review the presenting symptoms of an enrollee and must pay for all services involved in the screening examination where the presenting symptoms (including severe pain) were of sufficient severity to have warranted emergency attention under the prudent layperson standard. If a Medicaid beneficiary believes that a claim for emergency services has been inappropriately denied by a MCO, the beneficiary may seek recourse through the MCO or BMS appeal process.
6. **Referrals:** When an enrollee's PCP or other MCO representative instructs the beneficiary to seek emergency care in-network or out-of-network, the MCO is responsible for payment for the medical screening examination and for other Medically Necessary emergency services, without regard to whether the patient meets the prudent layperson standard described above.

The MCO must promptly pay for all covered emergency services, including Medically Necessary testing to determine if a medical emergency exists, that are furnished by providers that do not have arrangements with the MCO. This includes emergency services provided by a non-participating provider when the time required to reach the MCO's facilities, or the facilities of a provider with which the MCO has contracted would have meant risk of permanent damage to the enrollee's health.

### **3.7.6 CAH Reimbursement**

MCOs contracting with CAH must make payment to CAH at the prevailing Medicaid reimbursement rate. MCO contracts with CAH must stipulate this reimbursement arrangement. Upon DHHR notification to the MCO of any changes to the CAH reimbursement rates, the MCO must update payment rates to CAH effective from the designated DHHR effective date. The MCO must pay the new rate for claims not yet paid with a date of service on or after the effective date of change. The new payment rate must be loaded into the MCO's claims payment system within thirty (30) calendar days of notification by the Department of the payment rate change.

### **3.7.7 Timely Payment Requirement**

The MCO must agree to make timely claims payments to both its contracted and non-contracted providers. A claim is defined as a bill for services, a line item of service, or all services for one enrollee within a bill. A clean claim is defined as one that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

The MCO must pay all clean electronic and paper claims for covered services from both in-network and out-of-network providers within thirty (30) calendar days of receipt, except to the extent the provider has agreed to later payment in writing.

The MCO must agree to specify the date of receipt as the date the MCO receives the claim, as indicated by its date stamp (including electronic date stamp) on the claim, and date of payment as the date of the check release or other form of payment release to the provider.

The MCO must submit monthly a claims aging report that provides information on all overdue clean claims for both in-network and out-of-network providers as noted in Appendix D.

The MCO must pay both in-network and out-of-network providers interest at eighteen percent (18%) per annum, calculated daily for the full period in which the clean claim remains unpaid beyond the thirty (30) calendar day clean claims payment deadline. Interest owed to the provider must be paid on the same date as the claim. The interest paid to the providers will not be reported as a part of the MCO encounter data. This provision does not apply to payments made due to a rate change per Article III, Section 3.7.9.

### ***3.7.8 Payments for Provider-Preventable Conditions***

Section 2702(a) of the Affordable Care Act (ACA) prohibits federal financial participation (FFP) payments to States for any amounts expended for providing medical assistance for Provider Preventable Conditions (PPCs), including health care-acquired conditions (HCACs) and other provider-preventable conditions (OPPCs). PPCs are hospital-acquired conditions not present on hospital admission, the wrong procedure performed on a patient, and procedures performed on a wrong patient or body part.

The MCO may not make payments for PPCs as defined by the federal regulations and DHHR policy in accordance with 42 CFR 438.6. The MCO will track PPC data and make it available to DHHR upon request.

### ***3.7.9 Medicaid Provider Rate Changes***

In the case of provider reimbursement that is tied to the Medicaid FFS rate schedule, the MCO is required to implement any rate changes adopted by the Department within thirty (30) calendar days of notification of the rate change. The MCO must pay the new rate for claims not yet paid with a date of service on or after the effective date of change. The MCO must reprocess any claims paid between the notification date and the system load date to the updated rate. This provision does not apply to payments made to CAH under Article III, Section 3.7.6 or payments made to FQHCs/RHCs per Article III, Section 3.4.1.

### ***3.7.10 Alternative Payment Models (APM)***

DHHR supports a value-based health care system where enrollee experience and population health are improved, the trajectory of health care cost is contained through aligned incentives with managed care organization and provider partners, and there is a commitment to continuous quality improvement and learning. To support this effort, the MCO is required to implement alternative payment models (APMs) that shift from FFM reimbursement to reimbursement that rewards improved delivery of health care. Beginning in SFY 2021, the Department will require a percentage of contracts be established that reimburse using APM. This percentage shall increase

in each subsequent contract year. While not enforced in the initial contract period, the MCO is encouraged to begin establishing contracts using an APM approach.

#### *3.7.10.1 Design of APM Models*

The MCO must design and implement payment models with network providers that tie reimbursement to measureable outcomes. APMs may include, but are not limited to the following:

1. Primary care incentives;
2. Payment for performance;
3. Shared savings arrangements;
4. Risk sharing arrangements;
5. Episodes of care/bundled payments; and
6. Capitation Payments with Performance and Quality Requirements.

Prior authorization and utilization management activities do not qualify as APMs.

#### *3.7.10.2 APM Activities Report*

The MCO is required to submit a report to DHHR annually on its APM activities. The report specifications are outlined in Appendix H but should include:

1. A thorough description of the MCO's APM initiatives;
2. Goals and outcome measures for the Contract year;
3. Description of monitoring activities to occur throughout the year;
4. Evaluation of the effectiveness of the previous year's initiatives;
5. Summary of lessons learned and any implemented changes;
6. Description of the most significant barriers; and
7. Plans for next Contract year.

#### **3.7.11 Requirements for Provider-Administered Drug Reimbursement**

All outpatient medical claims for provider-administered drugs must contain a Healthcare Common Procedure Coding System (HCPCS) code, a National Drug Codes (NDC) number, the NDC unit of measure, and the NDC quantity. The MCO must edit claims using the West Virginia's NDC to HCPCS Crosswalk file provided to the MCO monthly. The MCO must deny the entire claim or claim line item, if such a claim is missing the NDC information, or the NDC is not valid for the corresponding HCPCS code, as the drug is not considered a covered Medicaid benefit. This requirement applies to Medicare cross-over claims in addition to the other claims where a third party paid a portion of the claim.

### **3.8 Prohibitions on Inappropriate Provider Incentives**

The MCO must comply with regulatory requirements regarding provider incentives as specified in 42 CFR 417.479, 42 CFR 438.6(h), 42 CFR 422.208, and 42 CFR 422.210. The MCO may

not make specific payment, directly or indirectly, to a physician or physician group as an inducement to reduce or limit Medically Necessary covered services furnished to any particular enrollee. Indirect payments may include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future.

As specified in 42 CFR 417.479, MCOs that operate physician incentive plans that place physicians or physician groups at substantial financial risk must conduct enrollee surveys. These surveys must include either all current Medicaid enrollees or their representatives in the MCO and those who have disenrolled (other than because of loss of eligibility or relocation outside the MCO's service area) in the past twelve (12) months, or a statistically valid sample of these same enrollees and disenrollees. The surveys must address enrollee/disenrollee satisfaction with the quality of services provided and the accessibility of the services and must be conducted on an annual basis.

The MCO must collect the following information annually and make it available to DHHR and CMS upon request, within ten (10) business days.

- Whether services not furnished by the physician or physician group are covered by the incentive plan.
- The type or types of incentive arrangements, such as bonus, capitation.
- The percent of any bonus the plan uses.
- Assurance that the physicians or physician group has adequate stop-loss protection, and the amount and type of stop-loss protection.
- The patient panel size and, if the plan uses pooling, the pooling method.
- If the MCO is required to conduct enrollee/disenrollee surveys, provide a summary of the survey results to DHHR and, upon request, to enrollees.
- Information on the physician incentive plan to enrollees, upon request.

The MCO must comply with any additional rules regarding physician incentives released by CMS.

## **4. ENROLLMENT & ENROLLEE SERVICES**

The program will enroll the children and youth in the foster care system, individuals receiving adoption assistance, and children eligible and enrolled through the SED waiver in phase one (1). The MCO will be furnished with an enrollment roster that identifies individuals enrolled in the MCO, including all new enrollees, on a daily and monthly basis. All enrollment activities are subject to the standards and requirements set forth in this contract.

### **4.1 Marketing**

#### **4.1.1 Marketing Plan**

The MCO must submit a marketing plan to the Department for prior written approval by October 1<sup>st</sup> of each Contract year. If the marketing plan is modified during the Contract year, the revised marketing plan must be submitted to the Department for written approval prior to engaging in

any activities not specified in the original plan. The MCO marketing plan must comply with the DHHR Marketing Policies as described in Appendix C of this Contract.

#### **4.1.2 Marketing Materials**

The MCO must follow the marketing guidelines as described in 42 CFR 438.104 and Appendix C, DHHR Marketing Policies. All marketing materials must be prepared at a reading level no higher than the sixth grade and must satisfy the information requirements of this Contract to ensure that before enrolling in the MCO, individuals receive accurate oral and written information needed to make an informed decision on whether to enroll. Materials should use an easily readable typeface (such as twelve (12) or fourteen (14) point), frequent headings, and should provide short, simple explanations of key concepts. Technical or legal language should be avoided whenever possible. The MCO must submit evidence to DHHR that its materials satisfy this requirement<sup>12</sup> and provide a written assurance that marketing materials do not mislead, confuse or defraud enrollees or DHHR. Such written assurance must be provided annually or with each submission of new or revised marketing materials. Statements that will be considered inaccurate, false, misleading include, but are not limited to, any assertion or statement (whether written or oral) that:

- The potential enrollee must enroll in the MCO in order to obtain benefits or in order to not lose benefits; or
- The MCO is endorsed by CMS, ACF, the federal or state government, or similar entity.

Marketing materials that require DHHR review and approval include but are not limited to:

1. Marketing materials to potential enrollees;
2. Enrollee materials (Provider Directories, Member ID cards, etc.);
3. Information to be used on the MCO's Website or the Internet;
4. Print media;
5. Television and radio storyboards or scripts; and
6. Enrollee participation materials.

Any changes to marketing materials must be submitted to BMS for approval.

## **4.2 Enrollment**

### **4.2.1 Process**

The MCO will conduct continuous open enrollment during which the MCO must accept enrollees eligible for coverage under this Contract in the order in which they are enrolled without regard to health status of the enrollee or any other factors. The MCO will accept individuals who are eligible in the order in which they apply, without restriction unless authorized by the Regional Administrator (42 CFR 434.25) and up its enrollment limits as discussed below. The

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<sup>12</sup> Many commercial word processing software programs contain utilities for testing the readability of documents produced using the program.

MCO must accept enrollees in the order in which they apply (i.e., the order in which their enrollment information is transferred by the Department) up to the limits set by the Department. The MCO may not attempt to discourage or delay enrollment of eligible Medicaid enrollees.

#### *4.2.1.1 Pre-existing Conditions*

The MCO must assume responsibility for all covered medical conditions of each enrollee inclusive of pre-existing conditions as of the effective date of enrollment in the plan. The MCO must have a process for determining which enrollees may have pre-existing, chronic, or catastrophic illnesses, conducting outreach, and developing appropriate treatment plans for these enrollees as described in Article III, Section 6.3.

#### *4.2.1.2 Confinement to an Inpatient Care Facility at Time of Enrollment or Disenrollment*

Notwithstanding Article III, Section 8.6, Responsibility for Inpatient Care, if an enrollee is confined to an inpatient care facility on the effective date for initial enrollment with the MCO, coverage of inpatient facility charges (including charges at a transfer facility, if the enrollee is transferred during the stay, or within the facility) will be the responsibility of DHHR until the enrollee is discharged. The MCO is responsible for all other covered services provided on or after the effective date of MCO enrollment, including but not limited to emergency transportation, professional fees during the inpatient stay and outpatient care.

The MCO is responsible for all charges during the inpatient newborn stay if such newborn is born to a mother who is a current MCO enrollee until the newborn's discharge.

#### *4.2.1.3 Enrollment of Program Newborns*

The MCO must have written policies and procedures for enrolling newborn children of enrollees retroactively effective to the time of birth. These enrollment procedures must include transfer of newborn information to both DHHR and must provide for processing completion within thirty (30) calendar days of the date of birth. The MCO is responsible for all covered services provided under this contract to the newborn child during this time. The child's date of birth will be counted as day one. DHHR will pay a full month's capitation for all newborns. The MCO will receive capitation payments for all subsequent months that the child remains enrolled with the MCO. The MCO must inform the CPS worker of the birth of an infant to a child in Foster Care within one (1) business day of learning of the birth.

#### *4.2.1.4 Enrollment of Persons with Other Primary Coverage*

For enrollees with other primary coverage, the MCO must assume responsibility for Medicaid covered services that are not provided by the primary carrier. The MCO will defer utilization management decisions to the primary carrier, except for those Medicaid services and benefits that are carved out of the primary carrier's benefits package, which are the sole responsibility of the MCO.

#### **4.2.2 Assignment of Primary Care Provider**

The MCO must inform each enrollee about the full panel of participating providers. To the extent possible and appropriate, the MCO must offer each enrollee covered under this Contract the opportunity to choose among participating providers at the time of enrollment. This does not preclude the MCO from assigning a primary care provider to an enrollee who does not choose

one. The MCO may assign an enrollee to a PCP when an enrollee fails to choose one after being notified to do so. The MCO must set a period of time during which an enrollee may select a PCP, not to exceed five (5) calendar days after enrollment. Upon expiration of this time period, the MCO must assign the enrollee to a PCP. The assignment must be appropriate to the enrollee's age, sex, and residence.

The enrollee must be notified of this assignment and of the procedures for changing the designated provider. In the event that a PCP ceases to be affiliated with the MCO, the MCO's procedures must provide for notice to affected enrollees at least thirty (30) calendar days before the termination date and promptly assist enrollees in obtaining a new primary care provider.

#### **4.2.3 Enrollment Limits**

In accordance with 42 CFR 438.206, DHHR may establish a maximum Medicaid enrollment level for Medicaid beneficiaries for the MCO on a county-specific basis dependent on DHHR's evaluation of the capacity of the MCO's network. Subsequent to the establishment of this limit, if the MCO wishes to change its maximum enrollment level, it must gain DHHR's approval. The MCO must notify DHHR forty-five (45) calendar days prior to the desired effective date of the change. DHHR will issue its approval or disapproval in thirty (30) calendar days, subject to DHHR's timely receipt of all necessary information from the MCO to make the determination. If the change is an increase, the MCO must demonstrate its capability to serve additional enrollees. An increase will be effective the first of the month after DHHR confirms additional capacity exists.

#### **4.2.4 Disenrollments**

The term "disenrollment" will be used to refer to the process of enrollees leaving the MCO. Disenrollment for children in foster care may be initiated by DHHR or by the child's caregiver. Disenrollment for children and youth eligible and enrolled in the MCO through the SED waiver may be initiated by DHHR or the child's parents or guardians and will result in loss of SED waiver services and the child's MCO enrollment slot.

The MCO must have written policies and procedures for transferring relevant patient information, including medical records and other pertinent materials, when an enrollee is disenrolled from the MCO and enrolled in an MHT/WVHB MCO, a commercial health plan, or Medicaid FFS.

##### **4.2.4.1 MCO-Initiated Disenrollment**

Involuntary beneficiary disenrollment from the MCO may occur for the following reasons:

1. The beneficiary's permanent residence changes to a location outside the MCO's Medicaid service area.
2. Continuous placement in a nursing facility, State institution or intermediate care facility for the mentally retarded for more than thirty (30) calendar days;
3. Error in enrollment. This may occur if the beneficiary was inaccurately classified as eligible for enrollment in an MCO, if the beneficiary does not meet the eligibility requirements for eligibility groups permitted to enroll in an MCO, or after a request for

exemption is approved if the beneficiary was enrolled while their exemption request was being considered; or

4. Beneficiary death.

The MCO may not initiate disenrollment for any enrollee except as specified above; the MCO may not terminate enrollment because of an adverse change in the enrollee's health status; the enrollee's utilization of medical services; diminished mental capacity; or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO seriously impairs the entity's ability to furnish services to either this or other enrollees). The MCO may not request disenrollment because of an enrollee's attempt to exercise his or her rights under the grievance system. The MCO must assure DHHR that terminations are consistent with the reasons permitted under the contract. DHHR has responsibility for promptly arranging for services for any enrollee whose enrollment is terminated for reasons other than loss of Medicaid eligibility.

In the case of continuous placement in a nursing facility, State institution, or intermediate care facility for the mentally retarded for more than thirty (30) calendar days, the MCO must notify DHHR within five (5) business days following the 30<sup>th</sup> day of admission. The effective date of the disenrollment will be no later than the first day of the second month after the month in which the MCO requests termination. When notifying DHHR of its intent to disenroll an enrollee, the MCO must specify the reason for the request in order to assure DHHR that the reason for the request is consistent with the permissible reasons specified in this contract. DHHR will make the final decision to approve or deny the requested MCO-initiated disenrollment. If DHHR does not act on the MCO's request for a disenrollment, the disenrollment will be considered as approved.

*4.2.4.2 Enrollee-Initiated Disenrollment*

MCO enrollees eligible through adoption assistance may request disenrollment and return to Medicaid FFS at any time for any reason. Disenrollment will be effective no later than the first day of the second month after the month in which the enrollee requests disenrollment.

For children in foster care and adoption assistance, Medicaid beneficiaries will have a choice of one MCO or FFS in all 55 counties in West Virginia.

Children eligible through the SED waiver will be mandatorily enrolled in the specialized MCO with concurrent 1115 expenditure authority and will not have the option to disenroll into FFS.

### **4.3 Enrollee Services Department**

#### **4.3.1 General Requirements**

The MCO must maintain an Enrollee Services Department to assist enrollees in obtaining Medicaid and SNS covered services. The Enrollee Services Department, at the minimum, must be accessible during regular business hours, at least for nine (9) hours a day and through a toll-free phone number. The Enrollee Services Department must work with Medicaid enrollees, CPS workers, Adoptive and Foster Care parents, parents and guardians of children with an SED and providers to handle questions and complaints and to facilitate the provision of services.

The MCO must ensure that the toll-free enrollee services phone line meets the following minimum SLAs:

1. Eighty-three percent (83%) of calls are answered live within thirty (30) seconds during operating hours. Time measured begins when the enrollee is placed in the call queue to wait to speak to an Enrollee Services representative; and
2. The call abandonment rate does not exceed five percent (5%) of total calls for the month.

The MCO must be required to submit monthly reports outlining its performance against the above referenced measures and submit an attestation to its accuracy.

#### **4.4 Materials**

##### ***4.4.1 Enrollee Information***

The MCO must provide all paper and electronic informational materials (using a font size no smaller than twelve (12) point) relating to the Medicaid program in a manner and format consistent with the requirements of 42 CFR § 438.10. The enrollee must be informed that the information is available in paper form without charge upon request and must be provided with the information within five (5) business days. Electronic information must be placed on a website that is prominent and readily accessible. It must be provided in an electronic form which can be electronically retained and printed. Enrollee information provided by the MCO must be readable at the 6<sup>th</sup> grade level and easily understood, and available in the language(s) of the major population groups served and, as needed, in alternative formats (i.e., Braille) for those who are unable to see or read written materials. The MCO must make auxiliary aids and services, as well as oral interpretation services available in all non-English languages to all enrollees and potential enrollees free of charge. The MCO must notify enrollees that oral interpretation services are available for any language, that written information is available in prevalent languages, and how to access those services. Written materials must include taglines in the prevalent non-English languages and large print (in a font size no smaller than eighteen (18) point) explaining the availability of written translation or oral interpretation and the toll-free and TTY/TDY telephone number of the MCOs. MCOs must make its written material available in the prevalent non-English languages in its service area, as identified by DHHR in accordance with Article III, Section 4.7.

##### ***4.4.2 Member ID Cards***

The MCO must establish a process by which member ID cards can be obtained via an electronic portal and available by mail upon request. The card should not be overtly different in design from the card issued to the MCO's commercially enrolled enrollees. The MCO must issue all enrollees a permanent identification card within five (5) business days of enrollment through its electronic portal. The MCO may issue one (1) identification card for all covered benefits except for a dental benefit card, which may be issued separately. PCP information must be updated as soon as it becomes available. The MCO must issue a replacement card within five (5) business days of an enrollee's request. The MCO is not required to issue a new card if the enrollee has been previously enrolled with the MCO and received a card within the past twelve (12) months unless a new card is requested.

The card must include at least the following information:

1. Beneficiary name;
2. State-assigned beneficiary Medicaid identification number;
3. MCO name;
4. Twenty-four (24)-hour telephone number for use in urgent or emergent medical situations;
5. Telephone number for enrollee services (if different);
6. PCP name and office telephone number;
7. TTY number; and
8. The name of the MCO program (Specialized Managed Care Plan for Children and Youth).

The MCO must work with providers to educate that the MCO card is not necessary at the time of visit and help to educate providers on using their enrollment portal or the WVMMIS portal to confirm eligibility of the enrollee.

#### ***4.4.3 Enrollee Handbook***

The MCO must use the model enrollee handbook supplied by DHHR and insert MCO-specific material as directed in the template. The MCO must use the definitions included in the model handbook in enrollee communications.

The MCO must publish and keep current its enrollee handbook on the MCO website. Within five (5) business days of official enrollment notification to the MCO, the MCO must notify the new or returning enrollee's household of the availability of the enrollee handbook via:

- electronic format available on the MCO's website;
- email after obtaining the enrollee's agreement to receive the information by email; or
- auxiliary aids and services upon request at no cost for enrollees with disabilities who cannot access this information online.

The MCO must provide periodic updates to the enrollee handbook as needed explaining changes to the MCO policies, Medicaid program, or the foster care and adoption assistance program. When there are program or service site changes, notification will be provided to the affected enrollees at least fourteen (14) calendar days before intended effective date of the change. The MCO must maintain documentation verifying that the enrollee handbook is reviewed at least once a year. The MCO must notify its enrollees that an updated enrollee handbook is available at least annually after initial enrollment. The MCO must provide an enrollee handbook to enrollees within five (5) business days upon request.

##### ***4.4.3.1 Enrollee Handbook Requirements***

The handbook must include the following information which must adhere to the standards set forth in this contract:

1. Table of contents;

2. The phone number which can be used for assistance in obtaining emergency care;
3. A description of all available Contract services, including amount, duration, scope, and how to access those services (e.g., whether the enrollee can self-refer to the service or if a referral or prior authorization is needed); and an explanation of any service limitations or exclusions from coverage;
4. A description of any restrictions on the enrollee's freedom of choice among network providers;
5. The toll-free phone number for the enrollee services department, medical management, and any other unit providing services directly to employees, along with their hours of operation, and a description of its function;
6. Complaints, informal and formal grievance, appeal, and state fair hearing definitions and procedures, including:
  - a. The right to file grievances and appeals;
  - b. Filing procedures, requirements, and timeframes for complaints, grievances and appeals, and state fair hearing;
  - c. The method of obtaining a hearing and the rules governing representation at a hearing;
  - d. The right to request a State fair hearing after a determination has been made on an enrollee's appeal, which is adverse to the enrollee;
  - e. The availability of assistance if filing grievances and appeals, the toll-free numbers available for filing a grievance or appeal by phone;
  - f. The opportunity to have benefits continue if the enrollee files an appeal or request for a state fair hearing within DHHR specified timeframes upon request; and
  - g. The requirement that enrollees may have to pay the cost of services received while the appeal is pending, if the final decision is adverse to the enrollee;
7. How to report suspected fraud, wasted, or abuse;
8. Disenrollment policies;
9. How to obtain EPSDT services;
10. How to obtain SNS;
11. Information on family planning services, including a discussion of enrollees' right to self-refer to in-network and out-of-network, Medicaid-participating family planning providers;
12. Information on the process of selecting and changing the enrollee's primary care provider;
13. Information concerning policies on advance directives;
14. Explanation of emergency care, after hours care, urgent care, routine care and well-care, the process and procedure for obtaining each; and a statement that it is appropriate for an enrollee to use the 911 emergency telephone number for an emergency medical condition;

15. Explanation of what constitutes an emergency medical condition and emergency services;
16. The fact that prior authorization is not required for emergency services;
17. The enrollee's right to use any hospital or other setting for emergency care;
18. Procedures for obtaining services covered under the Medicaid State Plan or the Title IV State Plan and not covered by the MCO (e.g., prescription drugs, non-emergency medical transportation);
19. The extent to which and how to access post-stabilization services;
20. Limited MCO liability for services from non-MCO providers, e.g., only emergency care or referrals;
21. Information about choosing and changing PCPs;
22. Information about what to do when family composition changes;
23. Appointment procedures and access standards including travel time, scheduling standards and the MCO's standard waiting time;
24. Guidance to seeking care when out-of-area services are required, including authorization requirements and process;
25. How to obtain emergency transportation, Medically Necessary transportation and non-emergency transportation;<sup>13</sup>
26. How to obtain maternity and sexually transmitted diseases services;
27. How to obtain behavioral health and SUD services;
28. How to obtain SED waiver services and choose an appropriate SED waiver provider;
29. How to obtain non-emergency and emergency dental services;
30. Information on enrollees' rights to access certified nurse midwife services and certified pediatric or family NP services;
31. Procedures for recommending changes in policies or services;
32. What to do in the case of out-of-county and out-of-state moves;<sup>14</sup>
33. What to do if the enrollee has a worker's compensation claim, pending personal injury or medical malpractice law suit, or has been involved in an auto accident;
34. Information of contributions that enrollees can make toward their own health, enrollee responsibilities, appropriate and inappropriate behavior and any other information deemed essential by the MCO or the Department;
35. Information on enrollee rights and responsibilities, as outlined in this contract;

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<sup>13</sup> The MCO should contact the county BMS office to obtain information on how enrollees can obtain non-emergency transportation and Medically Necessary transportation.

<sup>14</sup> The MCO should contact the county BMS office to obtain information on what enrollees need to do in the case of out-of-county and out-of-state moves.

36. Any significant changes, as defined by the Department, to the information above, at least thirty (30) calendar days before the effective date of the change and no later than the actual effective date;
37. The MCO's policies regarding the appropriate treatment of minors;
38. The MCO must advise enrollees at least annually of their right to request and obtain the above information;
39. Cost-sharing policies, including but not limited to exemptions for certain categories of enrollees and services; and
40. Policies regarding the use of oral interpreters for minors and in case of emergency.

The MCO must make modifications in the enrollee handbook language, if directed to do so, to comply with the requirements as described above.

#### *4.4.3.2 Availability of Enrollee Handbook*

In addition, the MCO must make the following information available to enrollees on request:

1. Information on the structure and operation of the MCO;
2. The procedures the MCO uses to control utilization of services and expenditures;
3. The number of grievances and appeals and their disposition in the aggregate, in a manner and form specified by DHHR and/or Department of Insurance; and
4. A summary description of the method of compensation for physicians.

Some of the above information may be included as inserts or attachments to the handbook.

#### **4.4.4 Provider Directory**

The provider directory must include the provider names, locations with street address, website URLs (as appropriate), and telephone numbers of current contracted providers in the enrollee's service area. The directory must also include the non-English languages offered (including, but not limited to American Sign Language) by the providers or their interpreters; whether the provider has completed cultural competence training; identification of providers that are not accepting new patients; any provider group affiliations; provider specialties (as appropriate); whether the provider has office accommodations for people with physical disabilities (including offices, exam room(s), and equipment; and any restrictions on the enrollee's ability to select from network providers. This information should include, at a minimum, information on primary care physicians, specialists, general pediatric dentists, behavioral health providers, and hospitals.

The MCO must give affected enrollees reasonable notice of any changes regarding providers. The MCO must furnish a notice of any change in the names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area, including identification of providers that are not accepting new patients, at least thirty (30) calendar days before the intended effective date of the change.

The MCO must update the paper provider directory at least monthly, and the electronic provider directory must be updated no later than thirty (30) calendar days after the MCO receives updated

provider information. The MCO must notify beneficiaries annually of their right to request and obtain a provider directory. The MCO must provide potential enrollees a copy of the provider directory, upon request. The MCO must publish and keep current its provider directory on the MCO website. The MCO must provide enrollees a copy of its provider directory, upon request within five (5) business days.

The provider directory must also identify those providers that are renderers of SED waiver services, either by separately identifying that classification of provider, or denoting existing providers using a clearly defined symbol.

#### **4.4.5 MCO Internet Website**

The MCO must develop and maintain a public website to provide general information about West Virginia's Specialized Managed Care Plan for Children and Youth program, the provider network, customer services, and the complaints and appeals process for enrollees, foster families, adoptive families, parents or guardians of children enrolled with an SED,

CPS workers, and providers. The MCO must ensure that the enrollees, their families, and CPS workers have access to the most current and accurate information concerning the MCO's network provider participation.

The MCO is required to develop a secure portal with user specific log-in credentials that allow role-based appropriate access to confidential, child-specific information by July 1, 2020. The secure portal must include, but is not limited to:

- Enrollee-specific information,
- Service authorization statuses,
- Enrollee medical and SNS records (including assessments), and
- Enrollee eligibility information.

### **4.5 Education**

#### **4.5.1 New Enrollee Orientation**

The MCO must have written policies and procedures for orienting new enrollees about the following:

1. Covered Medicaid and SNS benefits;
2. The role of the primary care provider and how to select a PCP;
3. How to make appointments and utilize services;
4. What to do in an emergency or urgent medical situation and how to utilize services in other circumstances;
5. How to access carved-out services in the FFS system;
6. How to register a complaint or file a grievance;
7. Enrollees' rights and responsibilities; and
8. Contents of the enrollee handbook.

#### **4.5.2 Health Education and Preventive Care**

The MCO must provide a continuous program of general health education for disease and injury prevention and identification without cost to the enrollees. Such a program may include publications (e.g., brochures, newsletters), media (e.g., films, videotapes), presentations (e.g., seminars, lunch-and-learn sessions) and classroom instruction.

The MCO must provide programs of wellness education. Such programs may include stress management, nutritional education, prenatal care, human development, care of newborn infants and programs focused on the importance of physical activity in maintaining health. The MCO must provide tobacco cessation benefits for pregnant women, and children respectively. The MCO is not required to provide weight management services; the MCO may provide these services as a value-added service.

Additional health education and preventive care programs may be provided that address the social and physical consequences of high-risk behaviors. Examples include programs on the prevention of HIV/AIDS, unintended pregnancy, violence, SUD, tobacco use, sun exposure and protective devices such as seatbelts, safety helmets, and safety glasses. These programs must be conducted by qualified personnel. The MCO must also offer periodic screening programs that in the opinion of the medical staff would effectively identify conditions indicative of a health problem. The MCO must periodically remind and encourage their Medicaid enrollees to use benefits including physical examinations that are available and designed to prevent illness. The MCO must keep a record of all activities it has conducted to satisfy this requirement.

#### **4.5.3 Health Screenings**

The MCO may offer health screenings at community events, health awareness events, and in wellness vans to its enrollees and other members of the community. The MCO must instruct each enrollee that receives a screen to contact his or her PCP if medical follow-up is necessary and must ensure that each enrollee receives a printed summary of the assessment information to take to his or her PCP. The MCO is encouraged to transmit a summary of the assessment information directly to each enrollee's PCP.

#### **4.5.4 Advance Directives**

The MCO must comply with 42 CFR 422.128 relating to written policies and procedures respecting advance directives, including the following:

1. Providing written information to enrollees concerning their rights under State law to make decisions about their medical care, including accepting or refusing medical or surgical treatment, and to formulate advance directives and concerning the MCO's policies with respect to the implementation of such rights; this information should be included in the enrollee handbook;
2. Ensuring that written information reflects changes in State law as soon as possible, but no later than ninety (90) calendar days after the effective date of the change;
3. Documenting in the enrollee's medical record whether or not the enrollee has executed an advance directive;

4. Not conditioning the provision of care or otherwise discriminating against an enrollee based on whether the enrollee has executed an advance directive;
5. Ensuring compliance with requirements of state law respecting advance directives;
6. Providing education for staff and the community on issues concerning advance directives; and
7. Informing enrollees that complaints concerning noncompliance with the advance directive requirements may be filed with the Department survey and certification office.

For further information regarding advance directives, refer to 42 U.S.C. Section 1396a (w).

## **4.6 Enrollee Rights**

### ***4.6.1 Written Policies on Enrollee Rights***

The MCO must have written policies with respect to the enrollee rights specified below. The MCO must comply with any applicable Federal and State laws that pertain to enrollee rights. The MCO must articulate enrollees' rights, promote the exercise of those rights, and ensure that its staff and affiliated providers protect and take the rights into account when furnishing services to enrollees. The MCO must ensure that these rights are communicated to enrollees annually following initial enrollment; and to the MCO's staff and affiliated providers, at the time of initial employment or affiliation and annually thereafter. The MCO must also monitor and promote compliance with the policies by the MCO's staff and affiliated providers through analysis of complaints or grievances, requests to change providers, enrollee satisfaction surveys, and other sources of enrollee input. The MCO shall provide a copy of the Notice of Action to enrollees to help better understand the differences between complaints, grievances, appeals, and state fair hearings.

### ***4.6.2 Specification of Rights***

Each enrollee has a right:

- To receive information in accordance with the standards set forth in this contract;
- To be treated with respect and due consideration of his or her dignity and privacy;
- To accessible services;
- To choose providers from among those affiliated with the MCO;
- To participate in decision-making regarding his or her health care, including the right to refuse treatment;
- To receive information on available treatment options or alternative courses of care, presented in a manner appropriate to the enrollee's condition and ability to understand;
- To request and receive his or her medical records, and to request that they be amended or corrected, for which the MCO will take action in a timely manner of no later than thirty (30) calendar days from receipt of a request for records, and no later than sixty (60) calendar days from the receipt of a request for amendments,

in accordance with the privacy rule as set forth in 45 CFR parts 164.524 and 164.526, upon their effective dates, to the extent they apply;

- To obtain a prompt resolution of issues raised by the enrollee, including complaints, grievances, or appeals and issues relating to authorization, coverage, or payment of services;
- To offer suggestions for changes in policies and procedures;
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other Federal regulations on the use of restraints and seclusion; and
- To be furnished health care services as set forth in this contract.

#### *4.6.2.1 MCO's Policies and Procedures to Protect Enrollee Rights*

MCOs must have policies and procedures to protect and promote these rights, as follows:

##### **1. Enrollee privacy**

The MCO must implement procedures to ensure the confidentiality of medical records and any other health and enrollment information that identifies a particular enrollee in accordance with Article II, Section 6.8.

##### **2. Accessible services**

The MCO must ensure that all services, both clinical and non-clinical, are accessible to all enrollees, including those with limited English proficiency or reading skills, with diverse cultural and ethnic backgrounds, the homeless, and individuals with physical and mental disabilities. The MCO must also ensure that enrollees have the right to access emergency health care services, consistent with the enrollee's determination of the need for such services as a prudent layperson, and post-stabilization services.

##### **3. Provider choice**

The MCO must allow each enrollee to select his or her PCP from among those accepting new Medicaid enrollees in accordance with Article III, Section 4.2.

Each enrollee referred to a specific provider for any service other than primary care must have an opportunity to refuse care from the designated provider and to select a different affiliated provider.

##### **4. Provider-enrollee communications**

The MCO may not prohibit or restrict a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient for the following:

- The enrollee's health status, medical care or treatment options, including any alternative treatment that may be self-administered;
- Any information the enrollee needs for deciding among all relevant treatment options; or
- The risks, benefits and consequences of treatment or nontreatment.

##### **5. Participation in decision-making**

The MCO must permit the enrollee's authorized parent or authorized representative to facilitate care or treatment decisions when the enrollee is unable to do so. MCOs must provide for enrollee or authorized representative involvement in decisions to withhold resuscitative services, or to forgo or withdraw life-sustaining treatment, and comply with requirements of Federal and State law with respect to advance directives. This includes:

- Providing written information to clients concerning their rights under State law to accept or refuse medical or surgical treatment and to formulate advance directives and concerning the MCO's policies with respect to the implementation of such rights (this information should be included in the enrollee handbook);
- Documenting in the enrollee's medical record whether or not the enrollee has executed an advanced directive;
- Not conditioning the provision of care or otherwise discriminating against an enrollee based on whether the enrollee has executed an advance directive;
- Ensuring compliance with requirements of state law respecting advance directives; and
- Providing education for staff and the community on issues concerning advance directives.

The MCO may not prohibit or restrict a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient for the enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future decisions.

#### **4.7 Enabling Services**

The MCO must ensure that all services, both clinical and non-clinical, are accessible to all enrollees, including those with limited English proficiency or reading skills, with diverse cultural and ethnic backgrounds, the homeless, and individuals with physical and mental disabilities. The MCO must also monitor and promote compliance with these policies through analysis of complaints or grievances and appeals, requests to change providers, enrollee satisfaction surveys, and other sources of enrollee input.

##### **4.7.1 Communication Barriers**

The MCO is required to provide oral interpretive services for languages on an as-needed basis. These requirements extend to both in-person and telephone communications to ensure that enrollees are able to communicate with the MCO and providers and receive coverage benefits. Oral interpretive services must be provided free of charge to enrollees and potential enrollees and must be available for all non-English languages. The MCO must also provide audiotapes for the illiterate upon request.

DHHR will periodically review the degree to which there are any prevalent language or languages spoken by Medicaid beneficiaries in West Virginia (cultural groups that represent at least five percent (5%) of the Medicaid population). Within ninety (90) calendar days of notification from DHHR, the MCO will make written materials available in prevalent non-

English languages in its service areas. At the current time, there is no data to indicate that West Virginia has any Medicaid populations that meet this definition.

The MCO must notify enrollees and potential enrollees of the availability of oral interpretation services for any language and written materials in prevalent non-English languages. The MCO must also notify enrollees and potential enrollees of how to access such services.

#### **4.7.2 Sensory Impairments**

The MCO must develop appropriate methods for communicating with its visually- and hearing-impaired enrollees and accommodating the physically disabled. The MCO must have telecommunication device for the deaf (TDD) services available. MCO enrollees must be offered standard materials, such as enrollee handbooks, in alternative formats (i.e., large print, Braille, cassette and diskette for participants with sensory impairments).

#### **4.7.3 Cultural Competency**

The MCO must encourage and foster cultural competency among its providers. Culturally appropriate care is care given by a provider who can relate to the enrollee and provide care with sensitivity, understanding, and respect for enrollee's culture and background.

#### **4.7.4 Disabled Access**

The MCO must comply with the Americans with Disabilities Act (ADA); the ADA's requirements apply to both the MCO and its providers.

All facilities are readily accessible to, and usable by, individuals with disabilities, and auxiliary aids and services are provided to ensure effective communication, in compliance with Title III of the ADA.

### **4.8 Grievances and Appeals**

The MCO's grievance and appeals procedures must be understandable and accessible to legally responsible enrollees, adoptive parents, parents of children enrolled through the SED waiver, and CPS workers on behalf of the enrollees and must comply with federal requirements and must be approved in writing by the Department (42 CFR 434.32). The MCO may have only one (1) level of appeal for enrollees.

#### **4.8.1 Resolution of Enrollee Issues**

Enrollees or their authorized representative may file a grievance regarding any aspect of service delivery provided or paid for by the MCO at any time. The enrollee may file an appeal to seek a review of an adverse benefit determination taken by the MCO as defined in 42 CFR 438.400(b). The MCO must submit to the Department a quarterly report summarizing each grievance and appeal handled during the quarter and a quarterly report summarizing all grievances.

##### **1. MCO Requirements**

The MCO must establish internal grievance and appeal procedures (informal and formal steps) that permit an eligible enrollee, or a provider on behalf of an enrollee, to challenge the denials of coverage of medical assistance or denials of payment for medical

assistance and for the enrollee to receive continuation of benefits while the MCO appeal and the State fair hearing are pending as outlined in this section:

- a. The MCO must establish and maintain a grievance and appeal procedure, which has been approved by the State, to provide adequate and reasonable procedures for the expeditious resolution of grievances initiated by enrollees or their providers concerning any matter relating to any provision of the MCO's health maintenance contracts, including, but not limited to, claims regarding the scope of coverage for health care services; denials, reductions, or cancellations of enrollee coverage; failure to provide services in a timely manner, observance of an enrollee's rights as a patient; and the quality of the health care services rendered.
- b. A detailed description of the MCO's enrollee grievance and appeal procedure including the enrollee's ability to request continuation of benefits while the MCO appeal and the State fair hearing are pending must be included in the enrollee handbook provided to enrollees. This procedure must be administered at no cost to the enrollee.
- c. As part of MCO's enrollee grievance and appeal procedure, the MCO must:
  - i. Make available both informal and formal steps to resolve the grievance;
  - ii. Designate at least one grievance coordinator;
  - iii. Permit that both grievances and appeals can be filed orally or in writing;
  - iv. Provide reasonable assistance in completing the procedure, including but not limited to completing forms, auxiliary aids and services, and toll-free phone numbers with adequate TYY/TDD and interpreter capability as specified by the MCO;
  - v. Acknowledge receipt of grievances and appeals;
  - vi. Involve some person with problem solving authority at each level of the grievance procedure;
  - vii. Ensure that individuals, or their subordinates, reviewing and making decisions on grievances and appeals were not previously involved in decisions related to the grievance or appeal under review;
  - viii. Ensure that individuals reviewing and making decisions on grievances and appeals take into account all comments, documents, records, and other information submitted by the enrollee or their representative without regard to whether the information was submitted or considered in the initial adverse benefit determination;
  - ix. Ensure that individuals reviewing medically related grievances or denials of expedited resolution of an appeal have appropriate clinical expertise, as determined by the State in treating the enrollee's condition or disease;
  - x. Process and provide notice to affected parties regarding the enrollee grievance in a reasonable length of time not to exceed thirty (30) calendar days from the day the MCO receives the grievance, unless the enrollee requests an extension or the MCO shows that a delay is necessary and in the interest of the enrollee;

- xi. Ensure that standard resolution and notice for a grievance occurs with the timeframes established by DHHR and that such timeframes may be extended up to fourteen (14) calendar days upon the request of the enrollee or if the MCO shows that additional information is necessary and that the delay is in the interest of the enrollee; and
  - xii. Ensure that if the timeframe for resolving a grievance is extended for any reason other than an enrollee request, the MCO must give the enrollee written notice of the reason for the delay and inform the enrollee of the right to file a grievance if he or she disagrees with the decision.
- 2. In addition to the provisions stated above in Subsection 1c, the MCO's procedures with respect to appeals and grievances must provide that:
  - a. An address must be included for written appeals and formal grievances;
  - b. A provider may file an appeal on the enrollee's behalf with the enrollee's written consent;
  - c. No punitive action may be taken against a provider who files an appeal on behalf of an enrollee or supports the enrollee's appeal;
  - d. If an expedited appeal or review of a grievance is not requested, written and signed appeals and formal grievances must be filed following an oral appeal or formal grievance;
  - e. Enrollees must be provided with an opportunity to present in writing or orally, evidence and allegations of fact or law; the opportunity to examine his case file free of charge, including medical records, before and during the appeal or grievance as well as other documents considered during the appeal. Parties to the appeal must include the enrollee, his representative, or legal representative of a deceased enrollee's estate, and the MCO must inform the enrollee of the limited time available sufficiently in advance of the resolution timeframe for appeals;
  - f. The time limit for the enrollee or his representative to file an appeal is sixty (60) calendar days from the date on the notice of adverse benefit determination;
  - g. Provide that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date), and must be confirmed in writing unless the enrollee or provider requests expedited resolution;
  - h. The MCO must offer to meet with the enrollee or his representative during the grievance process;
  - i. The MCO must maintain an accurate record of each appeal and grievance, containing a general description of the reason for the appeal or grievance; the name of the covered person for whom the appeal or grievance was filed; the date received; the date of each review or review meeting; the resolution at each level of the appeal or grievance, if applicable; the date of resolution at each level, if applicable; and the record must be maintained in a manner accessible to the State and available to CMS or ACF upon request for no less than ten (10) years. Copies of the grievances and the responses thereto must be available to the public for inspection for five (5) years;

- j. The MCO must process and provide notice to affected parties regarding the appeal in a reasonable length of time not to exceed thirty (30) calendar days from the day the MCO receives the appeal, unless the enrollee requests an extension or the MCO shows that a delay is necessary and in the interest of the enrollee;
  - k. The MCO must process and provide notice to the affected parties regarding a grievance in a reasonable length of time not to exceed thirty (30) calendar days from the day the MCO receives the grievance, unless the enrollee requests an extension or the MCO shows that a delay is necessary and in the interest of the enrollee;
  - l. Standard resolution and notice of appeals must occur with the timeframes established by DHHR and may be extended up to fourteen (14) calendar days upon the request of the enrollee or if the MCO shows that additional information is necessary and that the delay is in the interest of the enrollee;
  - m. If the timeframe for resolving an appeal is extended for any reason other than an enrollee request, the MCO must give the enrollee written notice of the reason for the delay within two (2) calendar days and make reasonable efforts to give the enrollee prompt oral notice of the delay. The MCO must resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires. The MCO must inform the enrollee or his representative of the right to file a grievance if he or she disagrees with that decision; and
  - n. MCOs must provide written notice of the disposition of appeals which will include: the result, the date of the resolution, the right and procedure to request a state fair hearing, the right to receive continuation benefits while the hearing is pending, how to make the request for continuation benefits, and potential enrollee liability for the cost of continuation benefits if the state fair hearing upholds the MCOs decision.
3. The MCO must establish and maintain a process for the review and resolution of requests for an expedited appeals process regarding any denial, termination, or reduction of Medicaid or SNS covered services, which could seriously jeopardize the enrollee's health and well-being. This includes an appeal regarding any service related to an enrollee's formal treatment plan as developed by the MCO and PCP. The MCO must report these appeals to DHHR immediately, and DHHR will then determine the timeline for resolving the appeals. The expedited process for appeals must meet the requirements of Subsections one (1) and two (2) above and also must provide that:
- a. Expedited review of appeals is available upon request of the enrollee, his representative, or provider if the MCO determines that the timeframe for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function;
  - b. If a request for an expedited appeal is denied, the MCO must transfer the appeal to the standard resolution timeframe and make reasonable effort, as defined by DHHR, to provide prompt oral notice to the enrollee or his representative, followed up with written notice within two (2) calendar days, and resolve the

appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires;

- c. The MCO must inform the enrollee or his representative of the limited time available to present in writing or orally, evidence and allegations of fact or law;
- d. Resolution and notice for an expedited appeal must occur within the shorter of seventy-two (72) hours after the MCO receives the appeal. The seventy-two (72) hour timeframe may be extended by up to fourteen (14) calendar days upon the enrollee's request or if the MCO shows that additional information is required and that the delay is in the interest of the enrollee;
- e. The MCO must make reasonable effort to provide oral notice of disposition of an expedited appeal; and
- f. If the timeframe for resolving an expedited appeal is extended for any reason other than an enrollee request, the MCO must give the enrollee written notice of the reason for the delay.
- g. In the event that the MCO fails to adhere to notice and timing requirements, the enrollee is deemed to have exhausted the MCO's appeal process, and the enrollee may initiate a state fair hearing.

#### 4. Review of Appeal Decisions

None of the foregoing procedures precludes the right of enrollees to request a fair hearing before the Department of Health and Human Resources as part of an enrollee's right to fair hearing related to applications for eligibility and decisions to suspend, terminate, or reduce services as specified in 42 CFR 431.220 and 42 CFR 438.400. The MCO must implement any decision made by the Department pursuant to such a review. Enrollees must exhaust all MCO grievance and appeals procedures and receive notice that the MCO is upholding the adverse benefit determination prior to requesting a state fair hearing. The enrollee or his representative must request a state fair hearing no later than one hundred twenty (120) calendar days from the date of the MCO's notice of resolution.

#### 5. Notice of Adverse Benefit Determination

The notice of adverse benefit determination must be in writing and must meet the readability requirements of Article III, Section 4.4 of this contract. DHHR will provide a model enrollee notice that the MCO is required to use.

- a. The notice must include the following information:
  - i. The adverse benefit determination taken or intended to be taken by the MCO;
  - ii. The reasons for the action, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. This information includes medically necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits;

- iii. The right of the enrollee, his representative, or his provider to appeal the adverse benefit determination to the MCO;
  - iv. The enrollee's right to request a state fair hearing, including information on exhausting the MCO's one level of appeal;
  - v. The procedures for filing an appeal and state fair hearing;
  - vi. Circumstances and procedures for requesting an expedited resolution; and
  - vii. The enrollee's right to and policies and procedures regarding the continuation of benefits while the resolution of the enrollee's appeal is pending.
- b. The notice of adverse benefit determination must be mailed:
- i. For termination, suspension or reduction of previously authorized Medicaid-covered services, at least ten (10) calendar days before the date of the adverse benefit determination;
  - ii. No later than the date of adverse benefit determination if:
    - o The MCO has evidence of the enrollee's death or that the enrollee no longer wishes services, has provided information that requires termination or reduction of services and understands the result of providing such information; has been admitted to an institution and is therefore no longer eligible under the plan; has been accepted for Medicaid services in another State, territory or Commonwealth;
    - o The enrollee's whereabouts are unknown, and the post office returns the enrollee's mail indicating no forwarding address;
    - o The enrollee's physician has changed the level of care prescribed;
    - o The notice involved an adverse determination made with regard to the preadmission screening requirements for NF admissions on or after January 1, 1989;
    - o The safety or health of individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the resident's urgent medical needs, or a resident has not resided in the nursing facility for thirty (30) calendar days (applies only to adverse benefit determinations for NF transfers); or
    - o The date of adverse benefit determination will occur in less than ten (10) calendar days in accordance with 42 CFR 438.12.
  - iii. For adverse benefit determinations due to probable fraud by the enrollee, no later than five (5) calendar days in advance of the action;
  - iv. For denial of payment, at the time of any adverse benefit determination affecting the claim;
  - v. Within fourteen (14) calendar days of the request for services when services under a standard service authorization decision are being denied or limited;

- vi. If the MCO extends the period for making standard authorization decisions in accordance with this contract, and must inform the enrollee of his right to file a grievance regarding the decision;
- vii. On the date the timeframes specified in this Contract expires, if those timeframes are not met; and
- viii. Within seventy-two (72) hours after the receipt of a request for an expedited authorization.

c. Information for Providers

The MCO must provide all providers and Subcontractors upon entering into a Contract with the Plan, the same information pertaining to the Plan's grievance, appeal and fair hearing procedures as was provided to enrollees as described in this section of this contract.

6. State Fair Hearing

The state fair hearing process will be the responsibility of the Department as delegated to the West Virginia Board of Review<sup>15</sup>. The MCO is responsible for cooperating with the State in the fair hearings process and is considered a party to state fair hearings. Other parties to the State fair hearing include the Department, the enrollee and his or her representative or the representative of a deceased enrollee's estate. The MCO's responsibilities include, but are not limited to the following requirements: providing any required documentation, participating in required meetings, and abiding by the Department's final decisions, including decision to settle a case with the enrollee. The MCO must also provide enrollees with information about the right to request a state fair hearing as set forth in this contract. Pursuant to the West Virginia Common Chapter §710.24, the State shall make a final decision within ninety (90) calendar days of the request for a hearing.

7. Continuation of Benefits

The MCO must continue the enrollee's benefits while an appeal or state fair hearing are pending when:

- The enrollee or the provider files the appeal timely (timely filing means on or before the later of within thirteen (13) calendar days of the MCO mailing of the notice of adverse benefit determination or the intended effective date of the MCO's proposed adverse benefit determination);
- The enrollee or provider is appealing a decision to terminate, suspend, or reduce a previously authorized course of treatment;
- The services were ordered by an authorized provider;
- The original period covered by the original authorization has not expired; and

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<sup>15</sup> State fair hearing process is conducted by the West Virginia DHHR Board of Review in accordance with the WV Common Chapter §710, Subpart A, Hearings for Applicants and Recipients of Public Assistance

- The enrollee requests extension of benefits.

Benefits must be continued or reinstated until:

- The enrollee withdraws the appeal or request for a state fair hearing;
- The enrollee fails to request a fair hearing and continuation of benefits within thirteen (13) calendar days after the MCO mails the notice of resolution of the appeal of an adverse benefit determination against the enrollee;
- or
- A state fair hearing office issues a hearing decision adverse to the enrollee.

If the resolution of the appeal or state fair hearing reverses the decision of the MCO to deny, limit, or delay services that were not furnished, the MCO must authorize or provide the disputed services promptly or as expeditiously as the enrollee's health condition requires, but no later than seventy-two (72) hours from the date it receives notice reversing the determination. If the resolution of the appeal or state fair hearing reverses the decision of the MCO to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the MCO must pay for those services in accordance with DHHR policy and regulations. However, if the final resolution of the appeal or state fair hearing is adverse to the enrollee, the MCO may recover the cost of services furnished to the enrollee while the appeal and state fair hearing were pending, to the extent that they were furnished solely because of the requirements of this section.

The MCO must resolve at least ninety-eight percent (98%) of enrollee appeals within thirty (30) calendar days from the date the appeal is filed with the MCO, unless the enrollee requests an extension or the MCO shows that a delay is necessary and in the interest of the enrollee.

#### **4.9 Cost-Sharing Obligations**

The MCO, through the MCO's providers, must impose copayments for covered services in the amounts that are determined by the Department in accordance with the requirements specified in the Medicaid State Plan and the requirements set forth in 42 CFR §§447.50 - 447.82.

The MCO must reduce payments to the network providers by the amount of the enrollee's copay, regardless of whether the provider successfully collects the copay. The MCO, or the MCO's providers, may not routinely waive required copays.

The MCO must have a process to track a quarterly household maximum for the cost-sharing obligations based on the enrollees' Federal Poverty Level (FPL).

##### **4.9.1 Services and Enrollees Exempt from Cost-Sharing Obligations**

The MCO and the MCO's providers may not charge copays to the following MCO enrollees or on the following services:

- Family planning services;
- Emergency services;
- Behavioral Health services;

- Enrollees under age twenty-one (21);
- Pregnant women (including the sixty (60) day postpartum period following the end of pregnancy);
- American Indians and Alaska Natives;
- Enrollees receiving hospice care;
- Enrollees in nursing homes;
- Any additional enrollees or services excluded under the State Plan authority; and
- Enrollees who have met their household maximum limit for the cost-sharing obligations per calendar quarter.

#### **4.9.2 Services and Enrollees Subject to Cost-Sharing Obligations**

The MCO and the MCO's providers must charge copays for the following MCO services or enrollees:

- Inpatient and outpatient services;
- Physician office visits, including but not limited to, office visits to an NP;
- Non-emergency use of an emergency department; and
- Any other enrollees identified by the MCOs that are not specifically exempt.

All enrollees eligible for services under Phase One are exempt from cost-sharing requirements.

#### **4.9.3 Cost-Sharing Obligations When Medicaid is Secondary Payer**

Enrollees who have primary insurance other than Medicaid are exempt from Medicaid cost sharing obligations. When a third party has made a payment for a covered service and the MCO is the secondary payer, the Medicaid allowed amount must be calculated as the difference between the paid amount and the Medicaid-allowed amount compared to the sum of the co-insurance, copayment, and deductible amounts. The MCO is responsible for paying the lesser of either the difference amount or the summed amount.

#### **4.10 Value-Added Services**

The MCO may propose to offer Value-Added Services. If offered, the MCO will not receive additional compensation for the Value-Added Services from the Department. The MCO may report the costs of Value-Added Services as allowable medical or administrative costs for the purposes of Medical Loss Ratio (MLR) calculation. The cost of Value-Added Services is not included in the MCO capitation rates. The Value-Added Services are not included in the Medicaid benefit package.

Value-Added Services must be submitted and approved by the Department as part of the MCO's initial readiness review during implementation and bi-annually. The MCO will submit the proposed Value-Added Services to the Department on the following schedule:

- By October 1<sup>st</sup> of each calendar year for the January 1<sup>st</sup> publishing date; and

- By April 1<sup>st</sup> of each calendar year for the July 1<sup>st</sup> publishing date.

For each Value-Added Service proposed, the MCO must:

- Define and describe the Value-Added Service;
- Specify the applicable service areas for the proposed Value-Added Service;
- Identify the category, group or managed care program of enrollees eligible to receive the proposed Value-Added Service if it is a type of service that is not appropriate for all enrollees;
- Note any limitations or restrictions that apply to the Value-Added Service; and
- Describe if, and how, the MCO will identify the Value-Added Service in the encounter data.

Since Value-Added Services are not Medicaid covered services or required SNS, there is no appeal or fair hearing rights for an enrollee regarding these services. A denial of a Value-Added Service will not be considered an adverse benefit determination. The MCO must notify an enrollee if a Value-Added Service is not approved. No-copays may be imposed for the Value-Added Services.

## **5. MEDICAID ADMINISTRATOR/CONTRACT LIAISON FUNCTIONS**

The MCO must employ a West Virginia Medicaid Administrator/Contract Liaison. The MCO's Medicaid Administrator(s) may also fulfill the duties of the Contract liaison, as outlined in Article II, Section 5.9 of the Contract. The Medicaid Administrator(s) must be responsible for making recommendations to management on any changes needed to improve either the actual care provided or the manner in which the care is delivered.

The person(s) must be in a position within the MCO that provides the authority needed to carry out these tasks and must be authorized and empowered to make and resolve operational and policy decisions within two (2) business days and financial decisions pertaining to claims payment issues within five (5) business days. The person(s) must demonstrate substantial experience in health care, experience working with low-income and foster care populations and cultural sensitivity. The person(s) serving as Medicaid Administrator(s) must be dedicated full-time to this function. The Administrator(s) need not be located full-time in West Virginia, but must be accessible through an 800 number and must be available in West Virginia as required. If the Administrator(s) are out of the office, there must be a designee available who can respond to the Administrator's duties within the required timeframe. The Administrator(s) will:

1. Investigate and resolve access and cultural sensitivity issues identified by MCO staff, State staff, providers, advocate organizations and beneficiaries;
2. Monitor MCO formal and informal grievances with the grievance personnel to look at trends or major areas of concern and discuss these reports with community advocates, if requested;
3. Coordinate with local Departments of Health and Human Resources, schools, community agencies, local health departments, state health laboratories and state agencies providing complementary services to Medicaid enrollees;

4. Recommend policy and procedural changes to MCO management including those needed to ensure and improve enrollee access to care and quality of care; changes can be recommended for both internal administrative policies and providers;
5. Function as a primary contact for beneficiary advocacy groups and work with these groups to identify and correct beneficiary access barriers;
6. Connect with local community organizations to acquire knowledge and insight regarding the special health care needs of beneficiaries;
7. Analyze systems functions through meetings with staff;
8. Organize and provide training and educational materials for MCO staff and providers to enhance their understanding of the values and practices of all cultures with which the MCOs interact;
9. Provide input to MCO management on how provider changes will affect enrollee access and quality/continuity of care; develop/coordinate plans to minimize any potential problems;
10. Review all informing material to be distributed to enrollees; and
11. Assist enrollees and authorized representatives to obtain medical records.

## **6. HEALTH CARE MANAGEMENT**

### **6.1 Second Opinions**

The MCO must provide for a second opinion from a qualified health care professional within the network, or arrange for the enrollee to obtain a second opinion outside the network, at no cost to the enrollee.

### **6.2 Out-of-Network Services**

The MCO must cover out-of-network services that are otherwise covered under the Contract for the enrollee if the MCO's network is unable to provide such services. The MCO must ensure that the cost to the enrollee is no greater than it would be if the services were furnished within the network. Services must be covered as adequately and timely as if such services were provided within the network, and for as long as the MCO is unable to provide them. To the extent possible, the MCO must encourage out-of-network providers to coordinate with the MCO with respect to payment.

### **6.3 Continuity and Coordination of Care**

The MCO must ensure continuity and coordination of care through use of an individual or entity that is formally designated as having primary responsibility for coordinating all services for the enrollee under this contract; the MCO must provide the enrollee or his representative with information on how to contact the designated individual or entity. The MCO must have a procedure to coordinate the services that the MCO provides to the enrollee with any services provided by other entities and to promote case management. The MCO must also have procedures for timely communication of clinical and other pertinent information among providers. Regardless of the mechanism adopted for coordination of services, the MCO must ensure that each enrollee has an ongoing source of primary care.

The MCO must have programs for coordination of care that include coordination of services with community and other social services generally available through contracting or non-contracting providers in the area served by the MCO. The MCO should also ensure that enrollees are informed of specific health care needs that require follow-up; receive, as appropriate, training in self-care and other measures they may take to promote their own health; and comply with prescribed treatments or regimens.

In the instance where an enrollee transfers enrollment to a MHT/WVHB MCO or FFS, the MCO is required to provide transition of care clinical information to the MHT/WVHB MCO or to the Department to promote continuity of care. The MCO must share with the State or other MCOs serving the enrollee.

### **6.3.1 Coordination of Care**

The MCO must have systems in place to ensure well-managed patient care, including at a minimum:

1. Management and integration of health care through primary care provider, or other means;
2. Systems to assure referrals for Medically Necessary specialty, secondary and tertiary care;
3. Systems to assure provision of care in emergency situations, including an education process to help assure that enrollees know where and how to obtain Medically Necessary care in emergency situations;
4. A system by which enrollees may obtain a covered service or services that the MCO does not provide or for which the MCO does not arrange because it would violate a religious or moral teaching of the religious institution or organization by which the MCO is owned, controlled, sponsored or affiliated;
5. Coordination and provision of EPSDT services as defined in Article III, Section 2.2; and
6. Policies and procedures that ensure the completeness of the case management record to include all results of referrals, consultations, inpatient records, and outpatient records.
7. Procedures to share, with the State or other MCOs serving the enrollee, the results of any identification and assessment of that enrollee's needs to prevent duplication of those activities.

The MCO must provide coordination services to assist enrollees in arranging, coordinating and monitoring all medical, behavioral, socially necessary, and support services. Each PCP is to act as the coordination of care manager for his/her patients' overall care.

The MCO must also designate an individual or entity to serve as a care manager for enrollees with ongoing medical conditions and special health needs. Responsibilities of the MCO's designee include assessing enrollees' conditions, identifying medical procedures to address and/or monitor the conditions, developing treatment plans appropriate for those enrollees determined to need a course of treatment or regular care monitoring, coordinating hospital admission/discharge planning and post-discharge care and continued services (e.g.,

rehabilitation), providing assistance to enrollees in obtaining behavioral health, SNS, and other community services, and providing assistance in the coordination of behavioral health, physical health and all other services.

The MCO must assist any Medicaid enrollee seeking information about workforce opportunities. The MCO must refer inquiries to a local workforce office for additional assistance in establishing employment. If the enrollee identifies a behavioral health or medical need that is preventing the individual from establishing employment, the MCO must make all reasonable effort to enroll the enrollee in care management and work with the enrollee to establish a care plan to help address these barriers.

As part of discharge planning, the MCO must make all reasonable effort to engage any enrollee exiting a drug rehabilitation program to determine whether employment assistance is needed. If so, the MCO must coordinate a referral to a local workforce agency and facilitate linkages to other related community supports available.

The MCO's notice to an enrollee and/or provider of its decision to deny, limit, or discontinue authorization of, or payment for, a service must specify the criteria used in denying or limiting authorization and include information on how to request reconsideration of the decision pursuant to the procedures. The notice to the enrollee must be in writing.

### **6.3.2 Coordination of Care with Other Entities**

#### *6.3.2.1 Family Planning*

Family planning services will be tracked, coordinated and monitored by the MCO. The MCO will assume financial risk for these services. Through its reimbursement of other providers, the MCO will be able to monitor enrollees' utilization of such services. Additionally, the MCO will ask in-network providers to educate enrollees about the release of necessary medical data to the MCO.

The MCO must ensure that enrollees who seek family planning services from the plan are provided with counseling regarding methods of contraception; HIV and sexually transmitted diseases and risk-reduction practices; and options to pregnant enrollees who may wish to terminate their pregnancies. The MCO will make appropriate referrals as necessary. All family planning services will be included in the encounter data that all health plans must report to DHHR.

#### *6.3.2.2 Fee-For-Service Health Care*

The MCO must follow established Medicaid procedures and provide referrals and assistance in scheduling appointments to enrollees in need of Medicaid covered services outside of the scope of this Contract as defined in Contract Appendix A. The MCO must also comply with all policies developed by DHHR for linking the services provided by the MCO to those non-covered services. These services will be tracked and monitored by the plans and DHHR through submission of encounter forms to DHHR.

#### *6.3.2.3 WIC Program*

The MCO must work with DHHR to provide for the coordination between the Medicaid program and the Special Supplemental Food Program for Women, Infants and Children (WIC) and must provide timely notice and referral to WIC in accordance with section 1902(a)(53) of the Social Security Act. The MCO must refer potentially eligible women (e.g., pregnant, breastfeeding, and less than six (6) months postpartum), infants, and children under the age of five (5) to WIC. The MCO must include timely (not more than sixty (60) calendar days) referral of medical information (length/height, weight, hemoglobin and medical condition which influences consumption, adsorption, or utilization of food nutrients).

#### *6.3.2.4 School-Health Related Services*

MCOs must work with the providers of school-health related services to coordinate care.

#### *6.3.2.5 Community and Social Services*

The MCO must have programs for coordination of care that include coordination of services with community and social services generally available through contracting or non-contracting providers in the area served by the MCO.

### **6.3.3 Coordination of Care for Persons with Special Health Care Needs and SSI Eligibles**

The MCO must have procedures for identifying individuals with complex or serious medical conditions. The MCO must complete identification and assessment of the individuals with complex or serious medical conditions within ninety (90) calendar days of the effective date of enrollment in the MCO. The MCO must use appropriate health care professionals in assessing those conditions, identifying medical procedures to address and/or monitor the conditions, and developing treatment plans appropriate for those enrollees determined to need a course of treatment or regular care monitoring. Treatment plans must specify an adequate number of direct access visits to specialists to accommodate implementation of the treatment plan. The MCO must make all efforts to assure that a person-centered treatment plan is developed in collaboration with the enrollee's primary care provider, with participation from the enrollee and the enrollee's care manager (if a separate care manager has been designated in addition to the PCP), and in consultation with any specialists caring for the enrollee; and must meet applicable quality assurance and utilization standards. These treatment plans must be reviewed and revised upon reassessment of functional need, at least every twelve (12) months, when the enrollee's circumstances or needs change significantly, or at the request of the enrollee.

If a treatment plan or regular care monitoring is in place, the MCO must have a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollee's condition and identified needs.

The MCO must share the identified needs and the MCO's assessment of enrollees with special health care needs with other entities serving those enrollees as appropriate to coordinate care. The MCO must ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with the requirements of 42 CFR parts 160 and 164 subparts A and E, to the extent they apply.

The MCO must have trained staff available to assist in the development of a clinical treatment plan and to work with the enrollee and PCP to facilitate specialty referrals, coordinate SNS, hospital admission/discharge planning, post-discharge care and continued services (e.g., rehabilitation), and to coordinate with services provided on a FFS basis.

#### *6.3.3.1 Associations with the Title V State Agency*

The MCO, through the Department, will coordinate with the Bureau for Public Health (BPH), Office of Maternal, Child and Family Health (OMCFH), to:

1. Make all reasonable efforts to assure that all enrollees with special health care needs, ages zero (0) to twenty-one (21), have access to a medical home and receive comprehensive, coordinated services and supports pursuant to national standards for systems of care for children and youth with special health care needs;
2. Make all reasonable efforts to assure better access to and receipt of the full range of screening, diagnostic, and treatment services covered under EPSDT;
3. Improve the rates and content of well child visits;
4. Improve care coordination for children with special health care needs, particularly those with multiple systems of care in place;
5. Make all reasonable efforts to assure children enrolled in Medicaid and their established plans of care are being met.

The Department, BPH, OMCFH, and the MCO will establish a Memorandum of Understanding (MOU) to implement coordination strategies to better serve children under the age of twenty-one (21), including those individuals with special health care needs, who are eligible for Medicaid managed care services. The MCO must collaborate with OMCFH care coordinators to share plans of care for children with special health care needs. The MCO must ensure that they do not duplicate services provided by OMCFH.

The MCO and OMCFH must share data necessary to improve service delivery and improved outcomes. Each entity must designate an individual to accept and coordinate all data requests. Use of individually identifiable MCO data will be limited to purposes directly connected to the purposes of rendering Medicaid services. All shared data will be subject to all applicable requirements regarding privacy and confidentiality and will be consistent with all State and Federal statutory requirements around the electronic submission of identifiable information.

The MCO and OMCFH will collaborate as appropriate on quality improvement activities, education, and other initiatives targeted at improving the care and health outcomes for children with special health care needs.

For any child with special health care needs requiring medical foods, the MCO should accept the clinical evaluations conducted by the BPH's OMCFH. OMCFH will provide the enrollee's MCO with the necessary information, including food type, amount, and duration, required to authorize medical foods. For MCO enrollees enrolled in the Title V Children with Special Health Care Needs program that do not require complete nutrition via tube, catheter, or stoma, the OMCFH will coordinate services with the nutritional foods vendor and the State's fiscal agent. The MCO is responsible for providing medical foods services for all other enrollees.

#### **6.3.4 Coordination with Chronic Condition Health Homes**

If an enrollee meets the requirements as defined in the Medicaid State Plan as qualifying for a chronic condition Health Home the MCO must notify the enrollee of the availability of designated Health Homes for his or her condition. The MCO will include Behavioral Health Homes in its Health Home network. Behavioral Health Home providers do not need to provide all the services of a traditional Medical Home themselves, but must ensure that the full array of primary and Behavioral Health Care services is available, integrated, and coordinated. If the enrollee chooses to participate, the MCO must facilitate a referral to the health home. DHHR shall provide a monthly Health Home enrollment list to the MCO so that coordination may occur between the MCO and the Health Home provider.

If the enrollee is participating in a chronic care Health Home, the Health Home must be notified of any use of emergency services and be notified of any inpatient admission or discharge of a Health Home enrollee that the MCO learns of through its inpatient admission initial authorization and concurrent review processes within twenty-four (24) hours.

#### **6.3.5 Transition of Care**

The MCO must have a transition of care policy to ensure continued access to services during a transition from FFS to a MCO, or transition from one MCO to another when an enrollee, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization as specified in 42 CFR § 438.62 (b). The MCO is required to identify and facilitate transitions for enrollees that are moving from one MCO to another or from a MCO to a FFS provider or to private insurance and require additional or distinctive assistance during a period of transition. The MCO must provide an enrollee care plan to the next provider of services (e.g. new MCO, parent, or provider) within fourteen (14) calendar days of their eligibility termination with the specialized MCO.

When relinquishing enrollees, the MCO must cooperate with the receiving MCO or FFS Medicaid regarding the course of on-going care with a specialist or other provider. Priority will be given to enrollees who have medical conditions or circumstances such as enrollees who:

- Are currently hospitalized;
- Are pregnant with high risk pregnancies in their third trimester, or are within thirty (30) calendar days of their anticipated delivery date;
- Are in the process of receiving a major organ or tissue transplantation service or which have been authorized;
- Have a chronic illness, which has placed the enrollee in a high-risk category and/or resulted in hospitalization or placement in nursing, or other, facilities;
- Are in treatment such as chemotherapy, radiation therapy, or dialysis;
- Have ongoing special health care needs such as specialized DME, including ventilators and other respiratory assistance equipment; and
- Are currently receiving home health services.

The enrollee must have access to services consistent with the access they previously had under the enrollee's previous MCO or FFS, and is permitted to retain their current provider for a period of ninety (90) calendar days, even if that provider is not in the MCO's network, while a transition of care plan is developed. As part of the transition of care planning, the enrollee will be referred to appropriate in-network providers for needed services. Enrollees with procedures that are scheduled to occur after their new MCO effective date, but that have been authorized by either BMS or the enrollee's original MCO prior to the new MCO effective date will be covered by the enrollee's new MCO until the end of the current authorization period as granted by either another MCO or FFS, or until the MCO has evaluated and assessed the enrollee and issued or denied a new service authorization as outlined in Article III, Section 6.4.1.

Enrollees that are in ongoing outpatient treatment that has been covered by BMS or another MCO prior to their new MCO effective date will be covered by the new MCO until the end of the current authorization period as granted by either another MCO or FFS, or until the MCO has evaluated and assessed the enrollee and issued or denied a new service authorization as outlined in Article III, Section 6.4.1.

The MCO will monitor providers to ensure transition of care from one entity to another to include discharge planning as appropriate. Consistent with federal and state laws, Medicaid FFS or the MCO that was previously serving the enrollee will fully and timely comply with requests for historical utilization data from the new MCO or with requests for copies of enrollee medical records from the enrollee's new provider(s), as appropriate.

In addition, the MCO is required to establish a transition plan for those members that are aging out of the child welfare system, and work to coordinate referrals to community resources the member could engage, as needed. Such services included, but are not limited to, health care, education, employment, housing and other social needs.

#### **6.4 Service Authorization (Prior Authorization)**

The MCO must adopt service authorization requirements that comply with state and federal laws governing authorization of health care services, including, but not limited to, West Virginia Code §33-25A-8s. The MCO must develop, maintain, and implement written policies and procedures, reflecting current standards of medical practice, for processing requests for initial authorization of services or requests for continuation of services. The policies must provide for consultation with the requesting provider when appropriate and must have mechanisms to ensure consistent application of review criteria and compatible decisions. The policies must specify information sources and the process used to review and approve the provision of medical services. The plan must have mechanisms to detect both underutilization and overutilization of services. Criteria for decisions on coverage and medical necessity must be clearly documented, based on reasonable medical evidence or a consensus of relevant health care professionals, and regularly updated. The MCO must ensure that the services are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished.

Decisions to deny service authorization or to authorize a service in amount, duration or scope that is less than requested must be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease and who has knowledge of local patterns of care, as determined by DHHR. As stated in Article II, Section 4.10 of this Contract,

the MCO may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary. The MCO may place appropriate limits on a service on the basis of criteria such as medical necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose.

Admission, continued stay, and discharge criteria used by the MCO should be communicated to all providers and enrollees when appropriate, and to individual enrollees when requested. In the case of any decision to deny, limit, or discontinue authorization of services, the MCO must notify the requesting provider and provide the enrollee written notice of such decision. The notice must meet the standards set forth in this contract.

The MCO must make authorization decisions and in the event of an authorization denial, provide written notice to the requesting provider and enrollee as expeditiously as required by the enrollee's health condition, and no later than seven (7) calendar days of receiving the request for service for the purposes of standard authorization decisions. This seven (7) calendar days period may be extended up to fourteen (14) additional calendar days upon request of the enrollee or provider, or if the MCO justifies to DHHR in advance and in writing a need for additional information and that the enrollee will benefit from such extension.

For at least ninety-five percent (95%) of authorization requests received, the MCO must make an authorization decision and in the event of an authorization denial, send a written notice within seven (7) calendar days of receipt of the authorization request. Failure to meet the ninety-five percent (95%) SLA in a given quarter, will result in liquidated damages of \$250,000 for each quarter in which that threshold is not met as outlined in Appendix F.

The MCO must provide an expedited authorization for services when the provider indicates that the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function. The MCO must make the expedited authorization decision and provide notice to the enrollee as expeditiously as the enrollee's health condition requires, but no later than two (2) business days after receipt of the request for service authorization. This two (2) day business period may be extended up to forty-eight (48) hours for expedited preservice authorizations and up to seventy-two (72) hours for expedited concurrent reviews upon request of the enrollee or if the MCO justifies to DHHR in advance and in writing a need for additional information and that the enrollee will benefit from such extension.

If the MCO places authorization requirements on durable medical equipment or other services necessary for an enrollee to be discharged from an inpatient stay, the MCO must provide a process for review of the service request within two (2) business days so as not to delay the enrollee's discharge. The MCO is prohibited from placing prior authorization requirements on oxygen concentrators.

The MCO may not structure compensation to persons or organizations conducting utilization management activities so as to provide inappropriate incentives for denial, limitation, or discontinuation of authorization of Medically Necessary covered services.

#### **6.4.1 Service Authorization Continuity of Care**

The MCO must ensure that the care of enrolled enrollees is not disrupted or interrupted. The MCO cannot require service authorization as a condition for payment for emergency care. The MCO cannot require service authorization for family planning services whether rendered by a network or out-of-network provider.

The MCO must provide a thirty (30) calendar day notice to providers before implementing changes to policies and procedures affecting the service authorization process. However, in the case of suspected fraud, waste, or abuse by a single provider, the MCO may implement changes to policies and procedures affecting the service authorization process without the required notice period.

The MCO must establish a process by which it obtains authorization and claims data from the enrollee's previous Medicaid provider to prevent access to care issues. The MCO must outline this process as an operational procedure document and submit to the Department for review and approval annually by July 1. For new enrollees, the MCO must allow the enrollee to continue to see existing providers for at least ninety (90) days as a transition of care policy.

In the event of documentation submission by a provider, placement agent, caseworker, enrollee or other third-party representative of the existence of a service authorization, the MCO must ensure enrollees receiving services through a service authorization from either another MCO or FFS receive continued authorization of those services for the same amount, duration, and scope for the shortest period of one of the following: (1) until the end of the current authorization period as granted by either another MCO or FFS, or (2) until the MCO has evaluated and assessed the enrollee and issued or denied a new service authorization.

#### **6.5 Rural Option**

If the MCO is the single MCO contracted to provide services in a rural county as permitted in 42 CFR 438.52, the MCO will permit enrollees to choose from at least two (2) physicians, and to obtain services from an out-of-network provider under any of the following circumstances:

- The service or type of provider, in terms of training, experience, and specialization, is not available within the MCO network;
- The enrollee's PCP or other provider determines that the enrollee needs related services that would subject the enrollee to unnecessary risk if received separately and not all of the related services are available within the network; or
- DHHR determines that other circumstances warrant out-of-network treatment.

In addition, enrollees may access an out-of-network network provider that is the main source of a service to the enrollee for the first sixty (60) calendar days of enrollment.

The provider must be given the opportunity to join the MCO network under the same terms and conditions as other providers of that type. If the provider chooses not to join the network, or does not meet the necessary qualifications to join, the enrollee will be transitioned to a participating provider within ninety (90) calendar days of enrollment, after being given an opportunity to select a participating provider.

## **6.6 Utilization Management**

The MCO must develop and implement written policies and procedures, reflecting current standards of medical practice, for processing requests for initial authorization of services or requests for continuation of services. Policies and procedures must satisfy the requirements for standard and expedited authorization of services, authorization criteria, and notice. The MCO must meet DHHR-specified standards for utilization management (service authorization) listed in this contract.

For beneficiaries that have primary insurance coverage from a source other than Medicaid, the MCO must honor coverage and utilization management decisions made by the primary carrier for those services in the primary carrier's benefits package. If the MCO is responsible for Medicaid services that are carved out of the primary carrier's benefit package, the MCO has utilization management responsibility for those carved out services.

## **6.7 Practice Guidelines and New Technology**

The MCO must adopt and disseminate practice guidelines that are based on valid and reliable medical evidence or a consensus of health care professionals in the particular field, consider the needs of the enrolled population, are developed in consultation with contracting health care professionals, and are reviewed and updated periodically. The guidelines should be disseminated to affected providers and to enrollees and potential enrollees upon request. The MCO must ensure that decisions with respect to utilization management, enrollee education, coverage of services, and other areas to which the guidelines are applicable are consistent with the guidelines.

The MCO must develop and implement written policies and procedures for evaluating new medical technologies and new uses of existing technologies.

## **6.8 Enrollee Medical Records and Communication of Clinical Information**

The MCO must compile and maintain, in a centralized database, encounter-level data on all Medicaid services provided under this contract and rendered by individual providers to enrollees and submit this information to DHHR. Medical records must also meet the standards specified in this contract. The MCO must implement appropriate policies and procedures to ensure that the MCO and its providers have the information required for effective and continuous patient care and for quality review, and must conduct an ongoing program to monitor compliance with those policies and procedures.

The MCO must ensure that each provider furnishing services to enrollees maintains an enrollee health record. PCPs must establish and maintain a confidential, centralized medical record for each enrollee that details care received. The medical record should demonstrate coordination of patient care; for example, relevant medical information from referral sources must be reviewed and entered into enrollees' medical records. Medical records must be maintained in accordance with standards established by the MCO that takes into account professional standards.

These standards must address health record content and organization, including specifications of basic information to be included in each health record that include at least the following:

- Information needed to conduct utilization review as specified in 42 CFR 456.111 and 42 CFR 438.211;

- Patient identification information: patient's name or patient ID number on each page or electronic file;
- Personal/biographical data: age, sex, address, employer, home and work telephone numbers, and marital status;
- Entry date;
- Provider identification;
- Allergies: medication allergies and adverse reactions are prominently noted on the record, absence of allergies (no known allergies-NKA) is noted in an easily recognizable location;
- Past medical history (for patients seen three (3) or more times): serious accidents, operations, illnesses, prenatal care and birth (for pediatric patients);
- Immunizations: for pediatric records (ages twelve (12) and under) there is a completed immunization record or a notation that immunizations are up-to-date, and when subsequent immunizations, if any, are required;
- Diagnostic information;
- Medication information;
- Identification of current problems: significant illness, medical conditions and health maintenance concerns are identified in the medical record;
- Smoking/ethanol/substance use: notation concerning cigarette and alcohol use and substance abuse is present (for patients fourteen (14) years and over and seen three (3) or more times);
- Consultations, referral and specialist reports: notes from consultations, lab, and x-ray reports with the ordering physician's initials or other documentation signifying review, explicit notation in the record and follow-up plans for significantly abnormal lab and imaging study results;
- Emergency care;
- Hospital discharge summaries: all hospital admissions which occur while the patient is enrolled in the plan, and prior admissions as necessary;
- Advance directives: documentation of whether or not the individual has executed an advance directive;
- Patient visit data: documentation of individual encounters must provide adequate evidence of, at a minimum:
  - History and physical examination, including appropriate subjective and objective information is obtained for the presenting complaints;
  - Plan of treatment;
  - Diagnostic tests;
  - Therapies and other prescribed regimens;

- Follow-up, including encounter forms with notations concerning follow-up care, or visits; return times noted in weeks, months or as needed; and unresolved problems from previous visits are addressed in subsequent visits;
- Referrals and results thereof; and
- All other aspects of patient care, including ancillary services.

Medical records must be legible, meaning the record is legible to someone other than the writer. Any record judged illegible by one (1) physician reviewer should be evaluated by a second reviewer. The MCO must have a process to assess and improve the content, legibility, organization, and completeness of enrollee health records. Enrollee health records must be available and accessible to the MCO and to appropriate state and federal authorities, or their delegates, involved in assessing the quality of care or investigating enrollee grievances or complaints.

The MCO must ensure that there is appropriate and confidential exchange of information among providers, such that a provider making a referral transmits necessary information to the provider receiving the referral, a provider furnishing referral service reports appropriate information to the referring provider, and all providers request information from other treating providers as necessary to provide care. When an enrollee chooses a new primary care provider within the network, the enrollee's records are transferred to the new provider in a timely manner that ensures continuity of care.

The MCO should have policies and procedures for promptly sharing enrollee information with any organization with which the enrollee may subsequently enroll.

## **6.9 Confidentiality**

The MCO must have written policies and procedures for safeguarding and maintaining the confidentiality of data, including medical records/enrollee information and adolescent/STD appointment records. The MCO's policies must be in accordance with the privacy requirements including, but not limited to 42 CFR 431.301-307, 45 CFR parts 160, 162, and 164 and with the Federal Information Security Management Act (FISMA), upon their effective dates, to the extent the requirements are applicable. All enrollee information, medical records, data and data elements collected, maintained or used in the administration of this Contract must be protected by the MCO from unauthorized disclosure. The MCO must provide safeguards that restrict the use or disclosure of information concerning enrollees to purposes directly connected with the administration of this contract.

### **6.9.1 Establishment of Confidentiality Procedures**

The MCO must establish confidentiality of data procedures:

1. To develop and promulgate policies in accordance with Federal and State law establishing who is authorized to receive such information;
2. To safeguard the privacy of any information that identifies a particular enrollee by ensuring that: information from the MCO or copies of records may be released only to authorized individuals; unauthorized individuals cannot gain access to or alter patient

records; and original medical records must be released only in accordance with Federal or State law, court orders, or subpoenas;

3. To address the confidentiality and privacy for minors, subject to applicable Federal and State law; and
4. To abide by all Federal and State laws regarding confidentiality and disclosure for mental health records, medical records, other health information, and any information about an enrollee.

#### **6.9.2 Maintaining Confidentiality of Medical Records**

The MCO, its staff, contracted providers, and all contractors that provide cost, quality, or medical appropriateness reviews or coordination of benefits or subrogation must maintain the confidentiality of medical record information and release the information only in the following manner:

1. All enrollee medical records are confidential and may not be released without the written consent of the covered persons or responsible party, except as specified below.
  - a. Written consent is not required for the transmission of medical record information to physicians, other practitioners, or facilities that are providing services to enrollees under a Subcontract with the MCO. This provision also applies to specialty providers who are retained by the MCO to provide services that are infrequently used or are of an unusual nature. This also allows for transfer of information (written or verbal) to DHHR staff and to DHHR Subcontractors.
  - b. Written consent is not required for the transmission of medical record information to physicians or facilities providing emergency care, or to the MCO, its staff, contracted providers or its contractors that are providing cost, quality, or medical appropriateness reviews or coordination of benefits or subrogation.
  - c. Written consent is required for the transmission of the medical record information of a former enrollee to any physician not connected with the MCO, except as set forth in (ii) above.
2. The extent of medical record information to be released in each instance will be based upon tests of medical necessity and a "need to know" basis on the part of the practitioner or a facility requesting the information. Medical records maintained by Subcontractors must meet the above requirements.

#### **6.10 Reporting Requirements**

The MCO must demonstrate the MCO's ability to provide the services under this Contract efficiently, effectively, and economically. As part of the MCO's demonstration of its ability, the MCO must comply with all Department reporting requirements. Such requirements encompass the content of the reports, the format in which they must be transmitted, and the timeframes for submission. Appendix D summarizes reporting requirements and timeframes. All MCO reports submitted under this Contract must reflect program-related data only unless otherwise requested by the Department.

The MCO must certify data submitted to DHHR and an authorized agent of DHHR, if such data is the basis upon which DHHR payments are made to the MCO. The data must be certified by the MCO's Chief Executive Officer (CEO) or Chief Financial Officer (CFO), or an individual who has authority to sign for and who reports directly to the MCO's CEO or CFO. The MCO must submit the certification concurrently with the certified data. The data that must be certified include, but are not limited to, enrollment information, weekly 837 encounter data submissions, and other information required by the Department and contained in contracts, proposals, and related documents.

#### **6.10.1 Quarterly Reports**

The MCO must provide DHHR with quarterly reports summarizing provider network, utilization, quality, access, EPSDT, and financial data in formats to be specified by DHHR, no later than the 15<sup>th</sup> day of the second month following the end of the reporting period.

The quarterly report must provide information on the number of Medically Necessary services contained within the categories of mandatory and optional services listed in Section 1905(a) of the Social Security Act but not covered under the State Plan.

#### **6.10.2 Grievance and Appeals Reporting**

The MCO must provide DHHR with quarterly reports documenting the number and types of informal and formal grievances and appeals registered by enrollees and providers, and the status or disposition of all grievances and appeals. Reports must be submitted no later than the 15<sup>th</sup> day of the second month following the end of the reporting period. At a minimum the reports must include:

- Total grievances (informal and formal) and appeals by nature of complaint under the following categories:
  - Service denied (e.g., non-covered, not Medically Necessary, out-of-area non-participating provider, no referral, referral denied, other);
  - Payment (e.g., disputed amount, timeliness, other);
  - Service complaints (e.g., inability to access an enrollee service representative and/or medical management staff by phone, enrollees' handbooks and evidence of coverage not sent to the enrollee within a reasonable period of time, misleading or outdated information noted in the MCO's provider directory, other); and
  - Quality of care.
- Total number of grievances (informal and formal) and appeals resolved in favor of the enrollee, against the enrollee, withdrawn, referred to formal process (if applicable), and the number remaining open.
- Total number of informal and formal grievances.
- Average, median, longest, and shortest turnaround time for informal and formal grievances.
- Average appeals resolution timeframe and percentage of appeals resolved within thirty (30) calendar days. The MCO must provide the total number of appeals

resolved after the required timeframe of thirty (30) calendar days and the reason for the extended resolution time.

#### **6.10.3 Enrollee Change in Circumstance Reporting**

The MCO or its subcontractor, to the extent that the subcontractor is delegated responsibility by the MCO for coverage of services and payment of claims under the contract between the state and the MCO, is required to implement and maintain procedures for prompt notification to the state when it receives information about changes in an enrollee's circumstances that may affect the enrollee's eligibility including:

- Changes in the enrollee's residence; and
- The death of the enrollee.

#### **6.10.4 Enrollee Satisfaction Reporting**

The MCO must survey a sample of its adult and child enrollees at least annually to determine enrollee satisfaction with the quality of MCO care and services. The MCO must use the latest available version of the CAHPS survey. The survey tool should support reporting of the U.S. DHHS' Core Quality Measures for Adults and Children. The MCO must use content or methodology as directed by DHHR. The MCO must submit to DHHR a copy of any results submitted to National Committee for Quality Assurance (NCQA) within five (5) business days of submission to NCQA.

A comprehensive analysis of survey results must be reported to DHHR annually, on or before August 15<sup>th</sup>. The analysis must include the methodology, overall response rate, and results for global ratings, composite scores, item-specific question summary rates, and any other measure specified by DHHR. If DHHR requires any additional measures to be reported from the survey results, DHHR will notify the MCO at the time it approves the survey tool.

The MCO must use survey results to identify and investigate areas of enrollee dissatisfaction, outline action steps to follow-up on the survey findings, and share findings with providers. Concurrent with submission of the analysis of survey results on August 15<sup>th</sup>, the MCO must submit its action plan to DHHR. The action plan must include implementation steps, a timeline for completion, and any other elements specified by DHHR. Along with the action plan, the MCO must submit an evaluation describing the effectiveness of the previous' years interventions. After the first submission, the MCO must submit updates on its progress in implementing the action plan forty-five (45) calendar days after the end of each quarter.

A separate satisfaction survey must be conducted for enrollees within the SED waiver program. Satisfaction results less than eighty-six (86) percent require the submission of a Corrective Action Plan (CAP) by the MCO to improve performance for the following contract period. Failure to submit the MCO CAP in a timely manner shall result in a liquidated damage, as defined by Appendix F.

#### **6.10.5 Encounter Reporting**

The submission of complete and accurate encounter data is a condition of capitation payment to the MCO by the Department.

The MCO is responsible for submitting complete and accurate encounter data for all services rendered that fall within the defined benefit package. The MCO must designate one (1) individual to work with the Department or its contractors on the submission of encounter data and resolution of any data issues.

#### *6.10.5.1 Encounter Data Submission*

All encounters must be submitted in electronic or magnetic format specified by DHHR. The format will be consistent with the formats and coding conventions of the CMS 1500 and UB92/UB-04 if and until DHHR determines that another standardized form is more appropriate. The MCO must attest to the truthfulness, accuracy, and completeness of all encounter data each time data is submitted to DHHR. Claims certificate is required from each provider submitting data to the MCO. The MCO must require its physicians who provide Medicaid services to have a unique identifier, which should be used in all encounter data submissions. The encounter data set will include at least those data elements as specified by DHHR or necessary for CMS to provide data at the frequency and level of detail specified by the Secretary of the federal DHHS.

Complete and accurate encounter data must be submitted monthly and no later than thirty (30) calendar days after the end of the period in which the service was paid. Encounter data must follow the format and data elements as required by the HIPAA-compliant 837 transaction for medical and dental claims.

Along with the encounter data submission, the MCO must submit:

- A detailed summary of the file submission to include total claims and dollars by service category;
- A detailed change log to include specifications for any change in the claims processing systems that has an impact of the representation of the data on the monthly encounter files. Examples of such changes include, but are not limited to, correction and adjustment processing, range and domain of extract variables, values of extract variables, and relationships between extract variables; and
- A dictionary containing definitions for all codes contained on the encounter record that are not defined in the public domain. Such variables include but are not limited to, provider specialty, type of service, place of service, and internal procedure codes.

#### *6.10.5.2 Changes to Encounter Data*

The MCO will be required to comply with any changes that the Department intends to implement within sixty (60) calendar days of issuance, unless otherwise agreed to in writing by the Department within thirty (30) calendar days of issuance.

The MCO must provide the Department with a written notice at least ninety (90) calendar days prior to any system conversions and changes in coding. It must also provide a plan to work with the Department to ensure consistency of encounter data.

#### *6.10.5.3 Encounter Data Reconciliation*

The MCO must reconcile the encounter data submitted to DHHR to the financial data that it reports to DHHR on a quarterly basis. The MCO must submit this reconciliation to DHHR by the 15th day of the second month following the end of the reporting period, along with the financial data. The MCO must explain differences of five percent (5%) or higher.

#### *6.10.5.4 Data Accuracy and Completeness Monitoring Program*

The MCO must have a data accuracy and completeness monitoring program in place that:

- Demonstrates that all claims and encounters submitted to the MCO by health care providers, including Subcontractors, are submitted accurately and timely as encounters to DHHR;
- Evaluates health care provider and Subcontractor compliance with contractual reporting requirements; and
- Demonstrates that the MCO has the processes in place to act on the information from the monitoring program and takes appropriate action to ensure full compliance with the encounter reporting requirement.

The MCO must submit an annual Data Accuracy and Completeness Plan to the Department for review and approval by October 1<sup>st</sup> for the current fiscal year. This Plan must include the three (3) elements listed above. Along with this submission, the MCO should submit documentation of its data file layout.

#### *6.10.5.5 Errors in Submitted Encounter Data*

The MCO must provide complete, accurate, and timely encounter data to DHHR. If previously submitted encounter data is identified with a significant number of errors, the MCO will be required to re-submit corrected encounter data within thirty (30) calendar days of notification from DHHR. If the MCO fails to meet a ninety-five percent (95%) encounter acceptance rate, it will be assessed a penalty of \$100 for each rejected encounter below the ninety-five percent (95%) acceptance rate.

#### **6.10.6 Healthcare Effectiveness Data and Information Set (HEDIS) Reporting**

The MCO must report audited HEDIS measures to DHHR annually by June 15<sup>th</sup>. Once the MCO performs NCQA's HEDIS Compliance Audit, the audited results must be submitted to DHHR upon submission to NCQA. DHHR will provide guidance to MCOs regarding which measures must be reported, according to the current version of HEDIS.

#### **6.10.7 National Core Health Care Quality Measures Reporting**

The Secretary of the DHHS has identified a set of core health care quality measures for Medicaid-eligible adults and children enrolled in Medicaid and CHIP. The MCO must report annually to DHHR results for all identified core adult and child quality measures relevant to the Contract covered services following the technical specifications provided by CMS. Results for the previous calendar year are due on or before September 1<sup>st</sup>. The MCO must use the most recent technical specifications from CMS, available at [www.medicaid.gov](http://www.medicaid.gov), to calculate results.

### **6.10.8 Financial Reporting**

Regular reporting is necessary to assure the ongoing operation and financial integrity of participating MCOs. The MCO must provide financial reports as specified by this Contract. Plans that are in a particularly weak financial position may be required to report more frequently.

1. *Annual Financial Statements:* Annually, on or before June 1<sup>st</sup>, the MCO must submit audited financial statements.
2. *West Virginia Offices of the Insurance Commissioner (OIC):* The MCO must submit copies of its quarterly and annual OIC reports, as well as any revisions thereto. The MCO must include applicable OIC reports on the solvency of its intermediaries. These reports are due on the same due dates for reporting to the OIC. Any revisions to a quarterly and/or annual OIC report must be submitted on the same day on which the report is submitted to the OIC.

The MCO must comply with all other financial reporting requirements as outlined in Article III, Section 8.

### **6.10.9 Provider Network Reporting**

The MCO must comply with reporting requirements required to assess compliance with network standards in a format and frequency to be specified by DHHR.

### **6.10.10 Reporting of Required Reportable Diseases**

Health care providers are required to report certain diseases by state law. This is to allow for both disease surveillance and appropriate case investigation/public follow-up. The MCO may be responsible for 1) further screening, diagnosis and treatment of identified cases enrolled in the MCO as necessary to protect the public's health, or 2) screening, diagnosis and treatment of case contacts who are enrolled in the MCO. Detailed infectious disease reporting requirements can be obtained from the Bureau for Public Health within the Department of Health and Human Resources. The three primary types of diseases that must be reported are:

1. *Division of Surveillance and Disease Control, Sexually Transmitted Disease Program.* According to WV Statute Chapter 16-4-6 and Legislative Rules Title 64, Series 7, sexually transmitted diseases (STDs) are required to be reported for disease surveillance purposes and for appropriate case investigation and follow-up. For contact notification, the MCO must refer case information to the Division of Surveillance and Disease Control. The Division has an established program for notifying partners of persons with infectious conditions. This includes follow-up of contacts to individuals with HIV and AIDS. Once notified, contacts who are enrollees of an MCO may be referred back to the MCO for appropriate screening and treatment, if necessary.
2. *Division of Surveillance and Disease Control, Tuberculosis Program.* As per WV Statute Chapter 26-5A-4 and WV Regulations 16-25-3, individuals with diseases caused by M. tuberculosis must be reported to the WV Bureau for Public Health, DSDC, TB Program for appropriate identification, screening, treatment and treatment monitoring of their contacts.
3. *Division of Surveillance and Disease Control, Communicable Disease Program.* As per WV Legislative Rules Title 6-4, Series 7, cases of communicable disease noted as reportable in West Virginia must be reported to the local health departments in the

appropriate time frame and method outlined in legislative rules. This both provides for disease surveillance and allows appropriate public health action to be undertaken—patient education and instruction to prevent further spread, contact identification and treatment, environmental investigation, outbreak identification and investigation, etc. (Note: Per legislative rule, reports of category IV diseases [including HIV and AIDS] are submitted directly to the state health department, not to local jurisdictions.)

The MCO must submit yearly statements to DHHR, by October 1<sup>st</sup>, attesting that it has provided written notification to all participating providers on their responsibility to and procedures for reporting the three primary types of diseases listed above to the State.

#### ***6.10.11 Federal Reporting Requirements***

The MCO must comply with the following Federal reporting and compliance requirements for the services listed below, and must submit applicable reports to DHHR. (See Medicaid Physician Provider Manual for state requirements and procedures):

- Abortions must comply with the requirements of 42 CFR 441. Subpart E – Abortions. This includes completion of the information form, Certification Regarding Abortion.
- Hysterectomies and sterilizations must comply with 42 CFR 441. Subpart F – Sterilizations. This includes completion of the consent form.
- EPSDT services and reporting must comply with 42 CFR 441 Subpart B – Early and Periodic Screening, Diagnosis, and Treatment.

MCOs must submit yearly statements to DHHR each year by October 1<sup>st</sup> attesting it has provided written notification to all participating providers on their responsibility to and procedures for reporting the three (3) primary types of diseases listed above to the State.

#### ***6.10.12 Annual Report***

The MCO must submit its annual report for the prior calendar year to DHHR by April 1<sup>st</sup>. The MCO's first annual report under this contract will be due April 1, 2021. The MCO must also make copies of the annual report available on its website and to its enrollees upon request.

#### ***6.10.13 Data Necessary for Drug Rebate Collection***

For provider-administered drugs provided under managed care, the MCO must submit to DHHR the drug utilization data necessary for the collection of drug rebates in formats to be specified by DHHR no later than fifteen (15) calendar days following the end of each month. The MCO must resolve any disputes related to the data within sixty (60) calendar days from notification of DHHR. The MCO must designate a single point of contact to coordinate rebate submissions and any disputes.

The data must include, but is not limited to the following for each provider-administered drug claim:

- a HCPCS code,
- an NDC number,

- the NDC unit of measure, and
- the NDC quantity.

The turnaround time on the resolution of an incorrect monthly data file must be submitted within fifteen (15) calendar days. The Department will return any rejected encounters to the MCO for correction and resubmission. The rejected encounters are to be resolved by the MCO within sixty (60) calendar days from the date of notification by DHHR or its designee.

Each pharmacy and medical encounter must include a 340B indicator, supplied by the provider at the time of billing, verifying whether or not a 340B drug was dispensed/administered to the Medicaid enrollee. The MCO must report this information using a standardized template supplied by the Department. The MCO must validate their 340B drug costs claim data by confirming that drug costs for 340B prescribed drugs do not exceed non-340B costs for the same drug and provide quarterly attestation that the verification has been completed.

The MCO is required to use the most current Medicaid crosswalk provided by the Bureau for processing Healthcare Common Procedure Coding System (HCPCS) claims. The crosswalk must be loaded into the vendor's claims processing system within thirty (30) calendar days of receipt for claims processing. If NDC on the submitted encounters do not align with the crosswalk, the claim line must be rejected by the MCO and returned to the provider for correction. The vendor must use and complete the specified file format for submitting HCPCS encounters for the Department for rebate processing.

#### ***6.10.14 Provider-Preventable Conditions***

The MCO must comply with any reporting requirements mandated by CMS to document the occurrences of provider-preventable conditions in the Medicaid program. The format and frequency will be specified by DHHR.

#### ***6.10.15 Other Reporting Requirements***

The MCO must submit to DHHR all Medicare and private accreditation review reports, findings, and other results from the previous three (3) year period, upon request.

The MCO must comply with any additional reporting requirements mandated by CMS during the course of this contract. DHHR will provide additional guidance on specific layouts and frequency.

The MCO must submit to DHHR a monthly report on the number of enrollees under age twenty-one (21) receiving Psychiatric Residential Treatment Facility (PRTF) services from in-state and out-of-state providers.

## **8. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI) PROGRAM**

The MCO must develop and implement written policies for an ongoing quality assessment and performance improvement program (QAPI) for the services it furnishes to enrollees. The QAPI must include several distinct, but interrelated comprehensive strategies and must be designed to achieve, through ongoing measurements and intervention, significant improvement in clinical

and nonclinical areas of care that are expected to have a favorable effect on health outcomes and enrollee satisfaction. Such improvements must be sustained over time. QAPI strategies should include:

- Annual measurement of performance in specified areas (e.g., immunization rates) and achievement of performance targets;
- Multi-year performance improvement projects addressing clinical and non-clinical areas;
- An approach for addressing systematic problems and critical incidents;
- The development and usage of a sufficient health information system; and
- Proper administration of quality assessment and performance improvement activities.

The MCO must submit performance measurement data to DHHR as required by DHHR. The QAPI must include mechanisms to detect both underutilization and overutilization of services, and to assess the quality and appropriateness of care provided to enrollees with special health care needs. The MCO must report on the status and results of projects annually. Projects must be completed within a reasonable timeframe. The basic elements of the MCO's QAPI must comply with the requirements set forth in this contract.

The MCO must also cooperate with DHHR initiatives aimed at assessing and improving program performance. These initiatives can include regular reporting to the State and an annual external quality review consisting of an on-site systems performance review of quality outcomes, timeliness of, and access to services covered under this contract. The MCO must make every effort to comply with external quality reviews that will be implemented by an organization contracted by DHHR. This may include participating in the design of the external review, collecting medical records and other data, and/or making data available to the external quality review organization.

### **7.1 Required Levels of Performance**

The MCO must meet certain required standards of performance when providing health care and related services to Medicaid managed care enrollees. The MCO must meet all goals for performance improvement on specific measures that may be established by DHHR. These minimum performance standards will be established by examining historical performance standards as well as benchmarks (best practices) of other health plans and delivery systems. Performance standards for each quality review period will be provided to the MCOs by DHHR.

### **7.2 Performance Improvement Projects (PIPs)**

The MCO must develop and maintain written descriptions of its performance improvement program, including the identification of individual(s) responsible for the program. The MCO must conduct performance improvement projects (PIPs) that are designed to achieve, through ongoing measurement and intervention, significant improvement sustained over time in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and enrollee satisfaction. PIPs must measure performance using objective quality indicators, implement system interventions to achieve quality

improvements, evaluate the effectiveness of the interventions, and plan and initiate activities for increasing or sustaining improvements.

An individual project involves selecting an aspect of clinical care or non-clinical services to be studied; specifying quality indicators to measure performance; collecting baseline data; identifying and implementing appropriate system interventions to improve performance; and repeating data collections to assess the continuing effect of interventions.

### **7.2.1 Areas of Focus**

Clinical focus areas include:

- Primary, secondary, and/or tertiary prevention of acute conditions;
- Primary, secondary, and/or tertiary prevention of chronic conditions;
- Care of acute conditions;
- Care of chronic conditions;
- High-volume services;
- High-risk services; and
- Continuity and coordination of care.

Non-clinical focus areas include:

- Availability, accessibility, and cultural competency of services;
- Interpersonal aspects of care, e.g., quality of provider/patient encounters;
- Appeals, grievances, and other complaints;
- Critical Incidents Reporting; and
- Effectiveness of communications with enrollees.

### **7.2.2 Projects**

The MCO must initiate<sup>16</sup> and maintain performance improvement projects that address the focus areas specified above. The MCO must maintain at least three projects at a time. The performance improvement projects may be selected by DHHR or required by CMS. In cases where DHHR does not specify a project focus, the MCO may select a specific topic within one of the identified focused areas. Project proposals must be approved by DHHR and the EQRO prior to project initiation.

The topics should be identified through continuous data collection and analysis; systematically selected and prioritized to achieve the greatest practical benefit for enrollees; and reflect the

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<sup>16</sup> A project has been initiated when it has proceeded at least to the point of baseline data collection. That is, the MCO has selected a particular aspect of care for performance measurement, identified the statistical indicator or indicators that will be used, and begun the process of collecting the data needed for an initial assessment of its performance on the indicator(s).

prevalence of a condition among, or need for a specific service by, the MCO's enrollees based on enrollee demographic characteristics, health risks, and any other special needs.

The MCO must use one or more quality indicators to assess its performance. The quality indicators must be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. Indicators should measure changes in health status, functional status, enrollee satisfaction, or valid proxies of these outcomes. The MCO will assess its performance on its selected indicators by collecting and analyzing reliable data on an on-going basis. The MCO must establish a baseline measure of its performance on each indicator, measure changes in performance, and continue measurement for at least one year after a desired level of performance is achieved. The MCO must annually submit performance measurement data to DHHR using DHHR-determined standard measures, including performance measures that may be developed by CMS.

If sampling is used, the MCO's sampling methodology must ensure that the data collected validly reflect the performance of all providers whose activities are the subject of the indicator; and the care given to the entire population (including special populations with complex care needs) to which the indicator is relevant.

The MCO must also demonstrate that its interventions result in meaningful improvement in its performance as evidenced in repeat measurements of the quality indicators specified for each performance improvement project undertaken by the MCO. The MCO must show that the performance improvement project is working effectively to reach defined quality goals by showing that an improvement occurred; is likely to result in a better outcome for the enrolled population; is attributable to the strength, duration and quality of the MCO's action(s), and not to "confounders" such as chance; and impacts high-volume, high-risk, and/or high-cost conditions or services.

Performance improvement projects are deemed successful and may terminate once sustained improvement is achieved. Sustained improvement is acknowledged through the documentation and maintenance of improved indicator performance. After improvement is achieved, it must be maintained for at least one year. The MCO must submit a CAP that addresses deficiencies identified in any measurement data.

Each performance improvement project must demonstrate effort to achieve meaningful improvement and be completed in a reasonable time period, as determined by DHHR. Project reports must be reported by July 15<sup>th</sup> in order to facilitate the use of resulting data in producing annual information on quality of care. The MCO is required to submit a performance improvement projects progress report forty-five (45) calendar days after the end of each quarter. The report must follow the DHHR-approved format.

### **7.3 Systemic Problems**

The MCO must correct significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms (such as notice from DHHR). The MCO must have written procedures for taking appropriate remedial action whenever inappropriate or substandard services are furnished, or services that should have been furnished were not. These written remedial/corrective action procedures should include:

- Specification of the types of problems requiring remedial/corrective action;
- Specification of the person(s) or body responsible for making the final determinations regarding quality problems;
- Specific actions to be taken;
- Provision of feedback to appropriate health professionals, providers and staff;
- The schedule and accountability for implementing corrective actions;
- The approach to modify the corrective action if improvements do not occur; and
- Procedures for terminating the affiliation with the physician, or other health professional or provider.

The MCO must prepare a CAP within thirty (30) calendar days of identification to correct any significant systemic problems. As actions are taken to improve care, the MCO must monitor and evaluate these corrective actions to assure that appropriate changes have been made, and track changes in practice patterns. The MCO must conduct follow-up on identified issues to ensure that actions for improvement have been effective.

Information resulting from QAPI activities will be used in recredentialing, re-contracting, and/or annual performance evaluation. QAPI activities must be coordinated with other performance monitoring activities, including utilization management, risk management, and resolution and monitoring of enrollee complaints and grievances. QAPI activities will be linked to other management functions of the MCO, such as network changes, benefits redesign, medical management systems, practice feedback to providers, and patient education and enrollee services.

#### **7.4 Health Information System**

The MCO must maintain a health information system that collects, integrates, analyzes, and reports data necessary to implement its QAPI program. This includes data on enrollee and provider characteristics, as well as on services furnished to enrollees as needed to guide the selection of performance improvement project topics, and to meet the data collection requirements for these projects, as specified above. The MCO's health information system must accept the MAID generated by DHHR for all enrollees for data collection and billing purposes. The health information system must also provide information including, but not limited to, utilization, claims, grievances and appeals, and disenrollment for reasons other than the loss of Medicaid eligibility. The MCO must ensure that information and data received from providers are accurate, timely, and complete by routinely reviewing reported data for accuracy, completeness, logic, and consistency, and by collecting service data in standardized formats to the extent feasible and appropriate. The MCO must make all collected data available to DHHR and upon request, to CMS in compliance with Section 6504(a) of the ACA.

#### **7.5 Administration of the QAPI Program**

The MCO's QAPI program must be administered through clear and appropriate administrative arrangements consistent with the Medicaid requirements of 42 CFR §438.240. The MCO must

ensure that sufficient resources and staff with necessary education, experience, or training are available to implement the QAPI.

#### ***7.5.1 Written QAPI Program Plan Description***

The MCO must have a written plan describing its QAPI program, including how the MCO will accomplish the activities required by this Section. The QAPI program plan at a minimum must specify clinical or health services delivery areas to be studied that represent the population served by the MCO in terms of age groups, disease categories, and special risk status. The QAPI program plan must describe the MCO's Performance Improvement Projects and any other quality activities that will be undertaken over a prescribed time period. The QAPI program plan must clearly identify the individuals responsible for the activities. Any additional MCO quality activities must use quality indicators that are measurable, objective, and based on current knowledge and clinical experience. The QAPI program plan must define a methodology and frequency of data collection that assures appropriate and sufficient monitoring to detect need for changes in the QAPI program plan.

#### ***7.5.2 Policymaking Body***

A policymaking body, defined as the governing body of the MCO or a committee of senior executives that exercises general oversight over the MCO's management, policies, and personnel, must oversee and be accountable for the QAPI program. The policymaking body must approve any changes in the QAPI program description and approve the annual work plan. The policymaking body must receive and review periodic reports on QAPI activities, as well as the annual evaluation, and take action on any resulting recommendations.

#### ***7.5.3 QAPI Committee***

A designated senior official must be responsible for the functioning of the QAPI program. If the responsible official is not the Chief Medical Officer, the MCO must show, through the QAPI program description or other documentation, that the Chief Medical Officer has substantial involvement in QAPI activities. The MCO's QAPI committee must meet at least quarterly to oversee QAPI activities and review of the process followed in the provision of health services. Providers must be kept informed about the written QAPI program. Contemporaneous records must document the committee's activities, findings, recommendations, and actions. The QAPI committee will report to the QAPI Policy committee on a scheduled basis on activities, findings, recommendations, and actions. Membership on the QAPI committee must include MCO employed or affiliated providers representative of the composition of the MCO providers. If affiliated providers are not represented on the MCO's QAPI committee or other core coordinating structure, there must be a clinical subcommittee or other advisory group to assure that clinicians actively participate in key activities.

#### ***7.5.4 Other QAPI Participants***

Employed or affiliated providers and consumers must actively participate in the QAPI program. All contracts with providers must require participation in QAPI activities, including provision of access to medical records, and cooperation with data collection activities. Consumer involvement should be sought from the outset of the MCO's QAPI program planning.

### **7.5.5 QAPI Communications**

The MCO must establish procedures for formal and ongoing communication and collaboration among the policymaking body and other functional areas of the MCO (e.g., health services management and enrollee services), especially with respect to:

- Resolving enrollee issues;
- Authorizing service;
- Developing practice guidelines;
- Recredentialing practitioners; and
- Providing feedback to providers and plan staff regarding performance and enrollee satisfaction surveys.

### **7.5.6 Annual Evaluation**

The MCO must formally evaluate, at least annually, the effectiveness of the QAPI program strategy, and make necessary changes. This annual evaluation must assess both progress in implementing the QAPI strategy and the extent to which the strategy is promoting the development of an effective QAPI program. The evaluation should assess whether activities in the MCO's work plan are being completed on a timely basis or whether commitment of additional resources is necessary. The final report should also include any recommendations for needed changes in program strategy or administration. These recommendations must be forwarded to and considered by the policymaking body of the MCO. The MCO must submit to DHHR a written evaluation of its QAPI program strategy by June 15<sup>th</sup> of each year.

## **7.6 MCO Accreditation**

The MCO must achieve or maintain accreditation from the NCQA for their Medicaid lines of business by the beginning of each Contract year. The MCO must keep current accreditation from the NCQA for their Medicaid lines of business. The MCO must provide DHHR with the accreditation status reports indicating the MCO evaluation option, evaluation measures, evaluation results, and evaluation length. The accreditation reports must be submitted upon completion of each accreditation survey.

Any new MCO entering into this Contract after July 1, 2013, must apply for accreditation with NQCA no later than nine (9) months from its operational start date in West Virginia. Any new MCO entering into this Contract after July 1, 2013, must become accredited with NQCA within two (2) years of its operational start date in West Virginia. The MCO must provide DHHR with the accreditation status reports indicating the MCO evaluation option, evaluation measures, evaluation results, and evaluation length. The accreditation reports must be submitted upon completion of each accreditation survey.

## **7.7 Performance Profiling**

The Department may publish information about MCO performance on a regular basis, identifying the MCO's performance indicators, and comparing that performance to other MCOs and to other external standards and/or benchmarks. The Department will allow the MCO opportunity to review its data for accuracy and/or validity prior to publication.

## **8.8 Quality Withhold Program**

Beginning under the second year of the contract, July 1, 2020, the State shall establish a quality withhold program that establishes quality metrics that align with the Department's goals as outlined under WV Code Chapter 49; requirements of the Department of Justice; and other HEDIS and CAHPS measures as selected by the Department.

On an annual basis, the Department or its designee will evaluate whether the MCO has demonstrated that it has fully met the performance measures for which the MCO is at risk. The Department or its designee will determine the extent to which the MCO has met performance measures by assessing each MCO's report relative to performance targets for the corresponding baseline year. If the MCO does meet some or all of the performance measures, the Department will issue a portion or entire sum of the withheld capitation as a lump sum payment to be paid no later than November of each corresponding year.

## **8. FINANCIAL REQUIREMENTS & PAYMENT PROVISIONS**

### **8.1 Solvency Requirements**

The MCO must make provisions against the risk of insolvency and assure that neither enrollees nor DHHR are held liable for debts in the event of the MCO's insolvency or the insolvency of any Subcontractors. The MCO must demonstrate adequate initial capital reserves and ongoing reserve contributions in accordance with the Insurance Commissioner's requirements. The MCO must provide financial data to DHHR in accordance with DHHR's required formats and timing.

The MCO must maintain a fiscally sound operation as demonstrated by the following:

1. Maintaining adequate liquidity to meet all obligations as they become due for services performed under the provider agreement.
2. Maintaining a positive net worth in every annual reporting period as evidenced by total assets being greater than total liabilities based on the MCO's annual audited financial statement. If the MCO fails to maintain a positive net worth, the MCO must submit a financial plan for DHHR approval outlining how the MCO will achieve a positive net worth by the next annual reporting period.
3. Maintaining a net operating surplus in every annual reporting period based on the annual audited financial statement. If the MCO fails to earn a net operating surplus, the MCO must submit a financial plan for DHHR approval outlining how the MCO will achieve a net operating surplus within available financial resources by the end of the next annual reporting period.

If insolvency insurance protection is carried as a rider to an existing reinsurance policy, the conditions of the coverage must not exclude the MCO's Medicaid line of business.

The MCO must notify DHHR in writing within sixty (60) calendar days if any changes are made to the MCO's insolvency protection arrangement.

The MCO must obtain adequate reinsurance, or establish a restricted fund balance for the purpose of self-insurance for financial risks accepted as part of this contract. Reinsurance arrangements are subject to approval by DHHR.

## 8.2 Capitation Payments to MCOs

### 8.2.1 Time and Manner of Payment

The MCO will be “at risk” for the services listed in Contract Appendix A (Description of Covered and Excluded Services) through a capitation payment system. The MCO will be paid a fixed rate PMPM for covered services and will not be permitted to collect any additional premiums from enrollees. The MCO shall also receive a fixed monthly payment for SNS administration that will be separate from the capitation received for medical services, and funded by the Bureau for Children and Families (BCF). The Department will automatically make capitation payments to the MCOs each month based on membership. The Department expects to process payments on the 16<sup>th</sup> and make capitation payments on the 20<sup>th</sup> of each month. MCOs will be required to submit a quarterly invoice to reconcile any differences between the capitation payments made by the Department and actual membership.

The Department is unable to provide a guarantee of payment. The Contract includes a provision that allows MCOs to terminate the Contract for non-payment upon a sixty (60) day written notice. The Department must then remedy the conditions contained in the notice within thirty (30) calendar days following the notice of termination or the MCO may terminate the contract.

The MCO must report to the Department within sixty (60) calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the contract.

All capitation payments are for a full month and not pro-rated. The enrollment termination date for an enrollee will always be the last day of the month. Capitation rates for full-month members have been adjusted to account for members with partial month enrollment, in which no capitation payment will be made for those partial month members. Capitation payments for the following special cases will be made as described below.

- **Individuals who age into a different rate cell during the month:** The age of an individual on the first of the month is used to determine the capitation rate cell for the whole month. If a person has a birthday in the middle of the month, the appropriate cell change will go into effect the following month.
- **Individuals who die during the month:** Should an enrollee die during the month, the MCO must inform Department immediately. The MCO will receive a capitation payment for that entire month. Any capitation payments paid following the month of the enrollee’s death will be recovered from the MCO.
- **Individuals who are institutionalized for more than thirty (30) calendar days:** If an enrollee has been in a nursing facility or state institution for thirty (30) consecutive calendar days, the MCO must inform the Department immediately. The MCO will receive a capitation payment for that entire month. For the remainder of that month, the MCO will be responsible for all medical costs not included in the bundled payment paid to the facility (which will be paid by the Department).

### 8.2.2 Risk Corridor

**For purposes of this contract, the State shall reimburse the MCO eighty percent (80%) of costs incurred that exceed ninety-five percent (95%) MLR for those services**

**meeting the reporting definition as outlined in Article III, Section 8.3.8.3  
Medicaid Medical Loss Ratio (MLR)**

The MCO is required to calculate and report Medical Loss Ratio (MLR) for each fiscal reporting year, consistent with MLR standards as outlined in 42 CFR 438.8(a). The MCO is required to maintain a MLR of at least eighty-five percent (85%) during the fiscal year reporting period for the entire Medicaid population. The MLR will be calculated by the MCO using the methodology as described in Appendix G of this Contract.

The MCO must submit an annual MLR report that documents the SED and non-SED populations separately, that will be used for rebating purposes in addition to separate detail broken out for the population in accordance with Appendix G of this Contract that includes at least the following:

- Total incurred claims
- Payments made under the Directed Payments Program as approved by CMS
- Expenditures on quality improvement activities
- Expenditures related to activities necessary to comply with program integrity requirements under this Contract
- Non-claims costs
- Premium revenue
- Taxes
- Licensing fees
- Regulatory fees
- Methodology(ies) used for allocation of expenses
- Any credibility adjustment applied
- MLR calculated by the MCO
- If applicable, any remittance owed to the Department
- A comparison of the information reported with the MCO's annual audited financial report
- Description of the aggregation method used to calculate total incurred claims
- Total enrollee months

An MLR percentage for each respective population of less than eighty-five percent (85%) must be one hundred percent (100%) reimbursable to the State.

If an MCO's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards.

MCOs, PIHPs, or PAHPs will aggregate data for all [Medicaid eligibility](#) groups covered under the contract with the [State](#).

#### **8.4 Health Insurer Fee**

The ACA Health Insurer Fee (HIF) and resulting income tax non-deductibility will be accounted for through an administrative allowance included in the capitation payment. The percentage allowance was calculated based on the anticipated liability for the Contract period. Once each MCO's final liability is known, the State will reconcile that to the amount paid through the capitation payments. If the amount paid is less than the liability amount, an increase will be made to future capitation payments. If the amount paid is greater than the liability amount, a decrease will be made to future capitation amounts.

#### **8.5 Third Party Liability (TPL)**

Under Section 1902(a)(25) of the Social Security Act, DHHR is required to take all reasonable measures to identify legally liable third parties and treat third party as a resource of the Medicaid beneficiary. The MCO must comply with W. Va. C.S.R. §9-5-11, as well as all applicable state and federal statutes, regulations and case law when identifying and collecting third party payments.

The MCO must pursue and require its Subcontractors to utilize or pursue, when available, covered medical and hospital services or payments for Medicaid managed care enrollees available from other public or private sources, including Medicare. This responsibility includes accident and trauma cases that occur while a Medicaid beneficiary is enrolled in the MCO. If there is no established liable third party at the time of service, but later a third party is identified as liable for the claim, the MCO should seek to recover the payment. This may occur when the Medicaid beneficiary requires medical services in casualty/tort, medical malpractice, Worker's Compensation, or other cases where the third party's liability is not determined before medical care is provided. It may also occur when the MCO learns of the existence of health insurance coverage after medical care is provided. The MCO or its Subcontractor should first seek recovery from the liable third party. If that is not feasible (for example, with Medicare), it may be necessary to recoup the payment from the provider and ask the provider to rebill correctly.

The MCO will retain all funds collected as part of this activity. The MCO must review service information to determine that all third party payment sources are identified and payment is pursued.

As part of this requirement, the State has determined that the MCO has the sole and exclusive responsibility and right to pursue, collect, and retain third party payment for services covered in the Medicaid managed care benefit package. MCO capitation payment rates are set accordingly. If the MCO determines that it will not pursue a Third Party Liability (TPL) case that is known to the MCO, the MCO must notify DHHR on the 15<sup>th</sup> of each month by submitting an electronic file, in a format to be specified by DHHR, listing these identified TPL cases. For these cases, DHHR or its contractor will have the sole and exclusive right to pursue, collect, and retain recoveries of these third party payments.

The MCO must also report TPL information in a file format to be specified by DHHR, including status updates on any cases identified for pursuit to DHHR on a monthly basis. The MCO must contact DHHR if it becomes aware that an enrollee has become eligible for Medicare while on Medicaid. It must also notify DHHR as it becomes aware of other insurance coverage.

Confidentiality of the information will be maintained as required by federal regulations, 42 CFR 431 Subpart F and 42 CFR Part 2.

### **8.5.1 Pay and Chase**

Even when TPL has been identified, the MCO must pay the claim and then seek payment from TPL in the following scenarios or for the following services:

- **Medical Support Enforcement** – if the claim is for a service provided to an individual on whose behalf child support enforcement is being carried out if: 1) the third party coverage is through an absent parent; and 2) the provider certifies that, if the provider has billed a third party, the provider has waited thirty (30) calendar days from the date of service without receiving payment before billing Medicaid. This requirement is intended to protect the custodial parent and the dependent children from having to pursue the non-custodial parent, his/her employer, or insurer for third party liability
- **Prenatal and Preventive Pediatric Services** – for claims for prenatal care and preventive pediatric services (including immunizations and EPSDT screenings and preventive services).
- **Labor & Delivery and Postpartum Care** – for claims for labor and delivery and postpartum care (but not for inpatient hospital costs associated with labor and delivery).
- **Right from the Start (RFTS)** – for claims for RFTS services

## **8.6 Special Payment Arrangements**

### **8.6.1 Responsibility for Inpatient Care**

Medical coverage of services at an inpatient care facility charges is considered to be the responsibility of the entity that the enrollee was enrolled under at the time of the initial inpatient facility admission (e.g., MCO, DHHR). Responsibility for medical inpatient care will be assigned accordingly in the following circumstances:

- **Disenrollment:** For the MCO enrollee receiving inpatient care at the time of disenrollment from managed care, coverage of inpatient facility charges (including charges at a transfer facility, if the enrollee is transferred during the stay, or within a facility) provided after the effective date of disenrollment will be the responsibility of the MCO until the enrollee is discharged. Coverage of all other covered services (including, but not limited to emergency transportation, professional fees during the inpatient stay and outpatient care) provided during the inpatient stay will be the responsibility of DHHR as of the effective date of disenrollment from the MCO. In the case of insolvency, the MCO must cover continuation of services to enrollees for duration of period for which payment has been made, as well as for inpatient admissions up until discharge.
- **MCO Transfer:** For the MCO enrollee receiving inpatient care at the time of transfer to another MCO, coverage of inpatient facility charges (including charges at a transfer facility, if the enrollee is transferred during the stay) provided after the effective date of transfer between the MCOs will be the responsibility of the

MCO in which the enrollee was enrolled at the time of the admission, until the patient is discharged from the inpatient facility. Coverage of all other services (including, but not limited to emergency transportation, professional fees during the inpatient stay and outpatient care) will be the responsibility of the MCO that the enrollee transfers to, as of the effective date of the enrollment into another MCO.

- **Inpatient Transfer:** For the prospective enrollee receiving inpatient care at the time of enrollment into the MCO and who transfers inpatient facilities as part of the same admission, coverage of inpatient facility charges provided after the effective date of the MCO enrollment will be the responsibility of DHHR. If an enrollee is discharged and admitted to another inpatient facility, coverage of all services provided at the inpatient care facility will be the responsibility of the MCO.

When a MCO enrollee under the age of twenty-one (21) is admitted to an inpatient facility and taken into the Department's custody during the same month, the MCO will assume liability for all services provided for as long as the enrollee remains on the MCO's enrollment roster and the MCO receives a capitation payment. During this time, the MCO must continue to provide all care coordination and service authorizations.

Article III, Section 8.6.1, Responsibility for Inpatient Care, does not apply to behavioral inpatient and residential care services.

#### ***8.6.2 Loss of Medicaid Eligibility***

The MCO is not responsible for the inpatient facility charges for a enrollee who is no longer eligible for Medicaid coverage as of the first of the month following the loss of Medicaid coverage.

#### ***8.6.3 Excluded Providers***

In accordance with 42 CFR 1001.1901(c)(5), payment under Medicaid is not available for excluded providers except for emergency medical services or items. To be payable, a claim for such emergency items or services must be accompanied by a sworn statement of the person furnishing the items or services specifying the nature of the emergency and why the items or services could not have been furnished by an individual or entity eligible to furnish or order such items or services. No claim for emergency items or services will be payable if such items or services were provided by an excluded provider who, through an employment, contractual or any other arrangement, routinely provides emergency health care items or services.

#### ***8.6.4 Maternity Kick Payments***

DHHR may provide special payments for certain maternity services, as outlined in Contract Appendix B, Capitation Rates.

#### ***8.6.5 Payments to Durable Medical Equipment (DME) Providers***

The MCO must reimburse at least one hundred percent (100%) of the current FFS Medicaid fee schedule to in-network durable medical equipment (DME) providers, unless such provider agreed to an alternative payment schedule. The Department will notify the MCO of any changes

in the FFS Medicaid schedule as soon as administratively possible. The MCO must adjust the reimbursement schedule to in-network provider within thirty (30) calendar days of the Department's notification of any changes in the FFS Medicaid schedule.

#### **8.6.6 Directed Payments to Certain Qualified Providers**

Directed Payments Program (DPP) is a program that provides qualifying providers with additional dollars as an access fee for Medicaid enrollees utilizing their services (inpatient admissions, outpatient claims, or physician visits) and focuses more dollars to higher need settings. Payments to providers will be based upon enrollee utilization of services at each provider during the quarter.

The providers will fall into one (1) of the following categories, with an associated dollar amount related to each category: urban, rural, tertiary safety net, and rural safety net.

DPP is established in accordance with CMS requirements, including:

- In accordance with 42 CFR § 438.6(c)(2)(i)(C), the Department expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per 42 CFR § 438.340;
- In accordance with 42 CFR § 438.6(c)(2)(i)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to Intergovernmental Transfer Agreements;
- In accordance with 42 CFR § 438.6(c)(2)(i)(F), the payment arrangement is not renewed automatically;

In accordance with 42 CFR § 438.6(c)(2)(i), the Department must assure that all expenditures for this payment arrangement are developed in accordance with 42 CFR §438.4, the standards specified in 42 CFR § 438.5, and generally accepted actuarial principles and practices.

Annually, the State will estimate the allocation to be assigned to each MCO rate cell using rate development based historical utilization for the estimated payment distribution. The quarterly provider payment will be calculated using actual time period utilization based on quarterly MCO reports on outpatient, inpatient, and physician touchpoints with three (3) months of paid claims run-out.

##### **8.6.6.1 DPP Allocations**

Allocations will be based upon the following:

1. Enrollee Category of Aid (COA);
2. Category of Service (COS) – Inpatient Admissions, Outpatient Visits, and Physician Visits; and
3. Provider Resource Level – Rural Non-Safety Net, Urban Non-Safety Net, Rural Safety Net, Urban Safety Net, Public Safety Net, Tertiary Safety Net, and Academic Physician Groups

The State will calculate an access fee for each touchpoint an enrollee has with a qualifying entity. A fixed dollar amount will be assigned to each service type and for each Qualified Provider type. No DPP funds will be applied to the maternity kick payments.

#### *8.6.6.2 Qualified Providers*

For the purposes of this subsection Qualified Providers include:

1. A nonstate, but government owned facility such as a county or city hospital;
2. University Practice Plans (affiliated with a public academic institution);
3. Public safety net hospitals;
4. Private hospitals, except for CAH; and
5. Hospitals identified as urban, rural, tertiary safety net, and rural safety net.

#### *8.6.6.3 Directed Payments to Providers*

The Department will pay the MCO a quarterly access payment for each Qualified Provider that is based on actual utilization of inpatient admits and outpatient services for hospital providers, or utilization of physician visits for University Practice Plans as reported in the MCO's quarterly report. The Department's quarterly access payments are made as retrospective lump sum payments.

The MCO must make payments to Qualified Providers based on the number of inpatient admits, outpatient claims, and/or physician visits. The Directed Payments must be sent to Qualified Providers within fifteen (15) calendar days after the MCO receives the amounts from the Department. These payments are in addition to any amount the MCO is required by agreement to pay for the provision of services under the Contract.

Dental and behavioral health services are excluded from the Directed Payments requirement.

#### *8.6.6.4 Directed Payments Reporting*

1. The Department will send each MCO a report along with its quarterly payment that indicates the amount of the total payment for each Qualified Provider.
2. The Department will send each Qualified Provider a quarterly report summarizing utilization per category of service by MCO used to determine the Directed Payments.
3. Within thirty (30) calendar days of receipt of payment of the Directed Payments from the Department, the MCO must submit a quarterly report indicating the following:
  - Qualified Providers that received Directed Payments;
  - Total amount paid to each Qualified Provider;
  - The date such Directed Payments were made to the Qualified Providers; and
  - The amount of total payment made to all Qualified Providers.

#### 8.6.6.5 Directed Payments Adjustment

The MCO is prohibited from making any changes to the DPP reimbursement levels unless at the direction of the Department.

No retroactive adjustments to the Directed Payments may be issued by the MCO to the Qualified Providers unless such retroactive adjustment was approved by the Department. The Department may treat such retroactive adjustments to a claim as a violation of Article III, Section 3.7, Timely Payment Requirement.

#### **8.6.7 Medicaid Institutions for Mental Diseases (IMD)**

Institution for mental diseases (IMD) means a hospital, nursing facility, or other institution of more than sixteen (16) beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for Individuals with Intellectual Disabilities is not an institution for mental diseases.

The MCO must contract with all accredited IMD facilities in the state of West Virginia.

Per 42 CFR 438.6(e), the MCO shall receive capitation payments for the enrollees aged twenty-one to sixty-four (21-64) admitted for inpatient treatment in an IMD, so long as the facility is a hospital providing psychiatric services.

Per 42 CFR 438.3(e)(2), “in lieu of services” are services or settings that are offered in place of services or settings covered under the Contract. “In lieu of services” must be medically appropriate and cost-effective. The MCO may offer the services or settings to enrollees and must receive enrollee consent to use the in lieu of services. The provision of inpatient psychiatric treatment in an IMD must meet the requirements for “in lieu of services.”

The MCO must be responsible for inpatient treatment in an IMD for up to fifteen (15) days during a calendar month. Both voluntary and involuntary commitments are the responsibility of the MCO. Placement in an IMD is considered an emergency service and as such, the MCO cannot require a prior authorization for placement in the IMD the first forty-eight (48) hours.

If an enrollee twenty-one (21) to sixty-four (64) has a stay(s) that exceeds fifteen (15) days in aggregate in a month, the responsibility of payment for coverage will transfer from the MCO to the Office of Health Facilities (OHF) starting on the sixteen (16th) day of the stay in the month. Once the stay exceeds fifteen (15) days in a month, OHF will be responsible for payment through the end of the stay under the following conditions:

- For voluntary patients after fifteen (15) days, medical necessity criteria must be met for payment to be issued by OHF; the MCO must retain the responsibility of determining medical necessity for the enrollee through the entire length of stay. No payment to the IMD may be issued for voluntary patients stays once medical necessity is not met.

- For involuntary patients, payment may be made by OHF prior to day sixteen (16) if medical necessity criteria are no longer met; however, it is the responsibility of the provider and the MCO to transition the patient to a more appropriate level of care in as timely a manner as possible once this criterion is not met. The State will conduct ongoing reviews of patients with stays beyond the medical authorization period to determine if corrective action is warranted.

For stays over fifteen (15) days in a month: the enrollee will remain enrolled in the MCO; the MCO will continue to receive PMPM payments for the enrollee; and the MCO will retain responsibility for any non-IMD covered services, including coordinating services at the appropriate level of care for the enrollee during discharge planning.

The MCO must submit to the Department a bi-monthly report identifying enrollees twenty-one (21) to sixty-four (64) with an IMD stay of greater than fifteen (15) days during the calendar month. This report must be provided to BMS on the 16<sup>th</sup> and 31<sup>st</sup> of each month.

The MCO must engage with the IMD facility to initiate discharge planning to facilitate the enrollee's successful return to the community. The MCO must make every reasonable attempt to identify appropriate outpatient services for the enrollee.

This IMD provision is not applicable to inpatient psychiatric hospital services for individuals under age twenty-one (21) as defined in 42 CFR 440.160.

## **8.7 Enrollee Liability**

The MCO cannot hold an enrollee liable for the following:

1. The debts of the MCO if it should become insolvent;
2. Payment for services provided by the MCO if the MCO has not received payment from DHHR for the services, or if the provider, under Contract or other arrangement with the MCO, fails to receive payment from DHHR or the MCO; or
3. The payments to providers that furnish covered services under a Contract or other arrangement with the MCO that are in excess of the amount that normally would be paid by the enrollee if the service had been received directly from the MCO.

## **9. FRAUD, WASTE, AND ABUSE REQUIREMENTS**

### **9.1 Fraud, Waste, and Abuse Guidelines**

#### **9.1.1 General Requirements**

Program Integrity requirements under the contract are outlined in 42 CFR 438.608 and are incorporated herein by reference. The MCO must have administrative and management arrangements or procedures that are designed to detect FWA. The procedures must include a method to verify with a sample of enrollees whether billed services were received. The MCO must submit its Medicaid compliance plan to the Department by October 1<sup>st</sup> each year. The compliance plan must include policies and procedures to prevent, detect, investigate, and report potential FWA incidences as outlined by DHHR. Funds misspent due to fraudulent or abusive actions by the organizations or its Subcontractors will be recovered. The MCO, and any

subcontractor responsible for coverage of services and payment of claims, must include a Regulatory Compliance Committee (RCC) on the Board of Directors and at the senior management level. The committee must be responsible for overseeing the organization's compliance program and its compliance with the requirements under the contract.

### ***9.1.2 Special Investigations Unit (SIU) and Coordination with the State***

In order to facilitate cooperation with the state, the MCO must establish and maintain a special investigations unit (SIU), either in-house or by Contract with another entity, to investigate possible acts of fraud, waste, or abuse for all services provided under the Contract, including those that the MCO subcontracts to outside entities. The MCO and MCO SIU must work with DHHR, the Medicaid Fraud Control Unit (MFCU), the Attorney General (AG), CMS, and ACF to administer effective FWA detection and prevention practices. The MCO must take part in coordination activities within the state to maximize resources for FWA issues. The MCO must meet regularly with DHHR, the MFCU and the EQRO to discuss plans of action, and attend FWA training sessions as scheduled by the State. MCO reporting procedures and timelines for FWA complaints and outcomes must meet State-established guidelines.

#### ***9.1.2.1 Program Integrity Staffing Requirements***

The MCO must have at least the equivalent of one full-time, West Virginia-based Program Integrity Professional who is dedicated one hundred percent (100%) to the WV Medicaid program and who can, at a minimum, perform the following duties:

1. Initiate investigations and develop FWA cases for future action.
2. Follow up appropriately on program integrity leads from the Department.
3. Execute and respond to requests for information (RFIs) from the MFCU, including MFCU data requests.
4. Execute and respond to RFIs from the Department, or other State actors.
5. Act as the point of contact for program integrity deconfliction.
6. Participate in West Virginia-based training, task forces, and other relevant meetings.

For initial implementation, the MCO must meet the staffing requirement within ninety (90) days of the contract effective date.

Outside the initial implementation period, the MCO must notify the Department of any absence or vacancy more than thirty (30) days and must include a contingency plan for fulfilling the program integrity requirements during the absence or vacancy.

#### ***9.1.2.2 Program Integrity Points of Contact***

The MCO must designate one (1) primary and one (1) secondary contact person for all DHHR Program Integrity and MFCU requests for data, records, or other information. DHHR or MFCU records requests will be sent to the designated MCO contact person(s) in writing via email, fax, or regular mail and will provide the specifics of the information being requested. The MCO must respond to the appropriate DHHR or MFCU staff enrollee within fourteen (14) calendar days or

within the timeframe designated in the request. If the MCO is unable to provide all of the requested information within the designated timeframe, an extension may be granted and must be requested in writing by the MCO no less than two (2) business days prior to the due date. The data, records, or information must be provided in the order and format requested.

### **9.1.3 Internal Compliance Plan**

The MCO or its subcontractor, to the extent that the subcontractor is delegated responsibility by the MCO for coverage of services and payment of claims under the contract between the state and the MCO, is required to implement and maintain a compliance program. The MCO and its subcontractors must have in place internal controls, policies, and procedures to prevent and detect FWA and must have a formal Medicaid compliance plan with clear goals, assignments, measurements, and milestones.

#### *9.1.3.1 Required Elements of the Internal Compliance Plan*

The MCO's Medicaid compliance plan must include the following elements:

1. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and State requirements;
2. The designation of a compliance officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the CEO and the Board of Directors;
3. The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organizations compliance program and its compliance with the requirements under the contract;
4. A system for training and education of the compliance officer and the organization's employees, including senior management, on state and federal standards and requirements under the contract;
5. Effective lines of communication between the compliance officer and the organization's employees;
6. Enforcement of standards through well-publicized disciplinary guidelines; and
7. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination with law enforcement in instances of criminal acts) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract.

#### *9.1.3.2 Required Procedures for the Internal Compliance Plan*

The MCO's Medicaid compliance plan must also include procedures for:

1. Conducting regular reviews and audits of operations to guard against FWA;

2. Verifying, through sampling or other methods, whether services reimbursed were actually furnished to enrollees, including documenting the results of verification activities;
3. Assigning and strengthening internal controls to ensure claims are submitted and payments are made properly;
4. Educating employees, network providers, and beneficiaries about FWA and how to report it;
5. Effectively organizing resources to respond to complaints of FWA;
6. Establishing procedures to investigate FWA complaints;
7. Establishing procedures for reporting information to DHHR; and
8. Developing procedures to monitor service patterns of providers, Subcontractors, and beneficiaries.

*9.1.3.3 Training of Senior Management, Employees, and Subcontractors*

The MCOs and its subcontractors' compliance program must include a system for training and education of the following individuals on the federal and state standards and requirements under the contract:

- The CEO;
- The CFO;
- The organization's senior management; and
- The organization's employees.

*9.1.3.4 Requirement to Monitor Provider and Beneficiary FWA*

The MCO must monitor provider fraud for underutilization of services and beneficiary/provider fraud for overutilization of services. Monitoring should include, but is not limited to the following:

1. Identifying provider FWA by reviewing for:
  - a. A lack of referrals;
  - b. Patterns of self referral;
  - c. Improper coding (upcoding and unbundling);
  - d. Billing for services never rendered;
  - e. Billing non-covered services as covered services;
  - f. Unqualified providers billing for services; or
  - g. Billing for medically unnecessary services.
2. Identifying beneficiary FWA by reviewing for:
  - a. Overutilization of services, including inappropriate emergency care; or
  - b. Card-sharing.

The MCO must submit a report summarizing the MCO's activities and results of these monitoring analyses for the current state fiscal year to DHHR by June 15<sup>th</sup> of each year.

The MCO must have procedures in place for prompt notification to the Department when the MCO becomes aware of an enrollee's death, change of address, or other changes in an enrollee's circumstances that may affect eligibility.

The MCO must have a procedure in place for prompt notification to the Department when the MCO becomes aware of a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the MCO.

#### **9.1.4 Fraud, Waste, and Abuse Reports**

The MCO must submit a report to DHHR within fifteen (15) calendar days of the end of each month regarding program integrity activities and suspected fraud, waste, and/or abuse identified during the prior month. The report must conform to the FWA Report template provided by the Department and must include complete information on the following program integrity activities:

- All program integrity activities initiated by the MCO or its contractors, and related outcomes;
- Referrals made to DHHR/MFCU;
- All overpayments identified, including those unrelated to program integrity (i.e., administrative overpayments), per 42 CFR 438.608; and
- All overpayments recovered, including those unrelated to program integrity (i.e., administrative overpayments), per 42 CFR 438.608.

The MCO must submit to DHHR by the 15<sup>th</sup> of each month the Suspension and Adverse Enrollment Action report for all in-network suspensions, terminations for cause, and provider credentialing denials and non-renewals for cause during the prior calendar month, as noted in Article III, Section 3.1.4 and Appendix D. See also Article III, Section 9.2, and Credible Allegation of Fraud.

The MCO will notify DHHR of all incidents of suspected fraud, waste, or abuse even if it is also referred to an entity other than DHHR such as the appropriate licensing and/or disciplinary bodies or other appropriate authorities.

#### **9.1.5 Investigations**

The MCO must cooperate and assist DHHR or any State or Federal agency charged with the duty of identifying, investigating, sanctioning, or prosecuting suspected fraud, waste, or abuse. The MCO is responsible for investigating possible acts of fraud, waste, or abuse for all services, including those that the MCO subcontracts to outside entities.

If the MCO identifies that fraud or abuse has occurred in the Medicaid program, based on information, data, or facts, the MCO must immediately notify the DHHR OPI following the completion of ordinary due diligence regarding a suspected fraud or abuse case. If DHHR OPI accepts the case for State investigation, the MCO may not engage in investigation efforts other than coordination efforts with the State. The DHHR OPI must supply a notice to the MCO notifying it of the case acceptance status no later than the tenth (10<sup>th</sup>) business day after the MCO notifies the DHHR OPI of the suspected fraud or abuse. The MCO may proceed with the

investigation or payment recovery efforts if the MCO receives a notice from the DHHR OPI and/or the MFCU indicating that the MCO is authorized to proceed with a case. Notification that MFCU does not accept the referral must be deemed authorization for the MCO to proceed with the case. If the MCO has not received a response from OPI after three (3) requests by the MCO, or within forty-five (45) calendar days of submission of referral, the MCO may proceed with its investigation up to and including recoveries.

#### ***9.1.6 Prevention and Detection***

The MCO must regularly submit encounter data as requested by DHHR, as well as other data specified in Article III, Section 6.10 of this contract. All other terms and conditions of the original Purchase of Service Contract will remain unchanged and in full force and effect.

#### ***9.1.7 False Claims Act***

Pursuant to Section 6032 of the Deficit Reduction Act of 2005, any entity who receives or makes Title XIX (Medicaid) payments of at least \$5,000,000 annually must establish written or electronic policies and procedures for the education of employees of affected entities regarding false claims recoveries.

### **9.2 Credible Allegation of Fraud**

42 CFR 455.23 requires the State Medicaid Agency to suspend all Medicaid payments to a provider after the Agency determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity unless the agency has good cause not to suspend payments or suspend payment only in part. The rules governing payment suspensions based upon pending investigations of credible allegations of fraud apply to Medicaid managed care entities.

#### ***9.2.1 Provider Payment Suspension***

The MCO is required to cooperate with the Department when payment suspensions are imposed on the Medicaid provider by the Department. When the Department sends notice that payments to a provider have been suspended, the MCO must also suspend payments to the provider within one (1) business day if such provider is in the MCO network and receives payments. When such notice is received from the Department by the MCO, the MCO must respond to the notice within three (3) business days and inform the Department of whether the MCO has implemented the suspension.

The MCO must also report all of the following information to the Department monthly: name of the suspended MCO provider, date the suspension was imposed, date the suspension was discontinued, reason for discontinuing the suspension, amount of payments held, and, if applicable, the good cause rationale for not suspending payment (for example, the provider is not enrolled in the MCO's network) or imposing a partial payment suspension. MCOs must include in their monthly report those providers that the MCO was notified of by DHHR. Reports must also include the amount withheld from providers on a cumulative basis. This information must be reported on the Suspension and Adverse Enrollment Action Report template created by the Department. If the MCO does not suspend payments to the provider, the Department may impose contractual remedies.

The Department is responsible for evaluating allegations of fraud and imposing payment suspensions, when appropriate, for those MCO providers who are a part of the State FFS network. The MCO is responsible for initiating payment suspensions based on the credible allegation of fraud for its in-network providers who are not a part the State FFS network. For payment suspensions initiated by the MCO, the MCO must comply with all requirements of 42 CFR 455.23. The MCO must report the following information to the Department within one (1) business day after suspension: the nature of the suspected fraud, basis for the suspension, date the suspension was imposed, date the suspension was discontinued, reason for discontinuing the suspension, outcome of any appeals, the amount of payments held, and, if applicable, the good cause rationale for imposing a partial payment suspension.

### **9.3 Treatment of Overpayments**

The retention of overpayments is dependent upon the circumstances under which such overpayments are identified and investigated. If the MCO does not identify and take action to recover provider overpayments in a timely manner, the Department reserves the right to identify, recover, and retain said overpayments. The Department will afford the MCO a reasonable grace period, as determined by the Department, to identify and recover overpayments from MCO providers before the Department will seek to recover and retain said overpayments.

The Department and the MCO will participate cooperatively in deconfliction procedures to prevent duplication of program integrity activities. The monthly FWA report submitted by the MCO pursuant to Article III, Section 9.1 of the Contract and the Department's Notice of Program Integrity Activities will be utilized as deconfliction tools. Deconfliction will occur regardless of the grace period determined by the Department.

#### **9.3.1 Department's Right to Collect from MCO**

The Department shall have the right to recover provider overpayments, including those overpayments due to WFA, from the MCO if:

1. the Department or its contractor identifies an overpayment made by the MCO to the provider;
2. the payment occurred outside the grace period, as defined by the Department;
3. the MCO has not previously identified the overpayment via the deconfliction process outlined herein; and
4. the MFCU or other law enforcement entity is not pursuing the provider.

The Department will send notice to the MCO with all information upon which the overpayment determination was based, along with a demand for payment. The MCO will enter into a payment agreement within thirty (30) calendar days of receiving notice, and effectuate payment within ninety (90) calendar days of notification. Failure to adhere to this process will result in liquidated damages as described in Appendix F. In the event that the MCO is invoiced for the overpayment by the Department, and the MCO recovers the overpayment from the provider, the provider's sole remedy is under the provisions of the provider's contract with the MCO. For provider appeals arising from actions taken pursuant to this section, the MCO must communicate the result of those appeals to the Department within sixty (60) calendar days of the final decision.

### **9.3.2 Department's Right to Collect from Providers**

The Department has the right to recover provider overpayments, including those overpayments due to fraud, waste, or abuse, from the provider if:

1. the Department or its contractor identifies an overpayment made by the MCO to the provider;
2. the payment occurred outside the grace period, as defined by the Department;
3. the MCO has not previously identified the overpayment via the deconfliction process outlined herein;
4. the MFCU or other law enforcement entity is not pursuing the provider; and
5. the Department, in its sole discretion, determines it is unable to collect from the MCO.

The Department will send notice to the MCO of its intent to collect from the provider and will initiate recovery actions with the provider. In the event that the Department chooses to exercise its right to collect the overpayment directly from a provider, the MCO assigns to the Department any rights it has to collect overpayments from the provider. Such payments recovered will be retained by the Department. The MCO must advise their providers, via contract provision, addendum, notice or other suitable method, of the State's right to collect overpayments pursuant to an assignment of rights as described in this section. The provider's appeal rights in the event of the Department collecting an overpayment directly from the provider are outlined in the BMS Policy Manual, chapter 800(B).

### **9.3.3 MCO's Right to Recover Overpayments**

The MCO must diligently engage in efforts to identify and recover overpayments that do not require a referral to the State. Overpayments identified and/or recovered must be reported on the monthly FWA report.

Unless otherwise specified in this contract, when the MCO or its subcontractor identifies overpayments, the may recover and retain those overpayments directly from the providers, if:

- a. the MCO was not required to abstain from collections from the provider, due to a MFCU or other law enforcement investigation;
- b. the Department has not duplicated this recovery, consistent with this section;
- c. the MCO followed proper procedures regarding fraud and/or abuse referrals to the Department;
- d. the MCO properly and timely disclosed the required information on its monthly FWA report;
- e. the encounter data is properly adjusted to reflect the recovery; and
- f. such recovery is not prohibited by federal or state law.

If the MCO fails to adhere to the prohibitions and requirements of this section, the MCO may be subject to forfeiture of the funds to the Department and the imposition of liquidated damages as described in Appendix F.

If an overpayment has been referred by the MCO to the Department, due to suspected fraud or abuse, and is subsequently returned to the MCO, the MCO may collect and retain these overpayments directly from the provider, consistent with this section. However, if the MCO has not taken action to collect the overpayment within ninety (90) calendar days of notification by the Department, the Department may collect and retain the monies.

If the Department identifies a suspected overpayment, also referred to as a “lead,” and refers that lead to the MCO for further investigation and recovery, the MCO will retain one hundred percent (100%) of its recoveries, pursuant to the requirements and prohibitions outlined in (a) through (f) above. If the Department has partially completed an audit or investigation, and, in its sole discretion, the Department refers that information to the MCO for further investigation and recovery, the Department and MCO may negotiate a percentage division of any recoveries to be split by the Department and the MCO, on a case-by-case basis. The Department reserves the right to resume the audit or investigation if no agreement as to percentage division of any recovery can be agreed upon. If the Department, or an entity contracting with the Department, performs the entire investigation leading to identification of the overpayment, thereby giving it the right to keep one hundred percent (100%) of the overpayment, the Department, in its sole discretion, may opt to divide the recoveries with the MCO in an amount determined by the Department.

Pursuant to 42 CFR 438.608(d)(1), this provision does not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations.

#### ***9.3.4 MCO’s Opportunity to Participate in Fraud Recoveries***

The MCO must submit fraud and abuse referrals to the Department using the prescribed form. Referral information submitted to the Department by an MCO will be distributed to all potentially impacted MCOs, along with a request for information (RFI). Upon receipt of the referral information and RFI, the MCO must respond by the due date included in the RFI. Failure to respond timely, completely, and accurately may result in the MCO not participating in any related fraud recoveries, and may also result in liquidated damages as described in Appendix F.

#### ***9.3.5 Provider Reported Overpayment***

In addition to internal processes to identify any overpayments, the MCO must have a process in place for network providers to report receipt of an overpayment. The provider is required to notify the MCO in writing of the reason for the overpayment and return the full amount of the overpayment to the MCO within sixty (60) calendar days after the date on which the overpayment was identified.

#### ***9.3.6 Impact on Medicaid MLR and Rate Setting***

Pursuant to 42 CFR 438, overpayment recoveries must be deducted from incurred claims when calculating the Medical Loss Ratio (MLR), and encounter data must be adjusted appropriately for rate setting purposes.

## **10. CHILDREN'S DENTAL SERVICES**

### **10.1 Children's Dental Services Administration <sup>17</sup>**

The MCO must provide children's dental services to individuals under twenty-one (21) years of age as covered services in an amount, duration, and scope reasonably expected to achieve the purpose for which the services are furnished. The MCO may place appropriate limits on a service on the basis of such criteria as medical necessity or for utilization control, consistent with the terms of this Contract and clinical guidelines.

The MCO may employ the services of a Dental Contractor serving as a dental benefit manager or utilization review agent if such a manager or agent covers the children's dental benefit equivalent to the requirements described in Appendix A and in accordance with this Contract. If the MCO elects to employ the services of a Dental Contractor or utilization review agent, the MCO is required to comply with all Subcontractor requirements outlined in this Contract.

### **10.2 Covered Dental Services**

The MCO covered services must be provided by a licensed dentist or dental specialist in an office, clinic, hospital, ambulatory setting, or elsewhere when dictated by the need for diagnostic, preventive, therapeutic, or palliative care, or for the treatment of a particular injury as specified in Appendix A of this Contract. Medicaid children's dental services include diagnostic services, preventive treatment, restorative treatment, endodontic treatment, periodontal treatment, surgical procedures and/or extractions, orthodontic treatment, complete and partial dentures, as well as complete and partial denture relines and repairs. Also included are adjunctive general services, injectable medications, and oral and maxillofacial surgery services.

### **10.3 Dental Director**

The MCO must have a qualified licensed dentist to serve as the Dental Director for the dental benefit. The Dental Director, or his or her designee meeting the qualifications described above, must be available for dental utilization review decisions and must be authorized and empowered to respond to dental clinical issues, utilization review, and dental quality of care inquiries.

### **10.4 Oral Health Fluoride Varnish Program**

The MCO must educate its network providers about the DHHR Infant and Child Oral Health Fluoride Varnish Program for Primary Care Practitioners, where PCPs may receive a reimbursement for fluoride varnish application. Providers are encouraged to complete the Smiles for Life Curriculum course prior to administering, but are not required to do so.

### **10.5 Coordination of Care**

Pursuant to 42 CFR 438.208, the MCO is responsible for the management of dental care and continuity of care for all affected MCO enrollees. The MCO or the MCO's PCP must urge enrollees to see their dental provider at least once every six (6) months for regular check-ups,

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<sup>17</sup> The MCO must cover the full scope of the dental services under the EPSDT coverage requirements for enrollees under twenty-one (21).

preventive pediatric dental care, and any services necessary to meet the enrollee's diagnostic, preventive, restorative, surgical, and emergency dental needs.

Per Article III, Section 2.2, the MCO's PCP must coordinate care by providing a direct referral to a dentist for children beginning at six (6) months after the first tooth erupts or by twelve (12) months of age as a part of the EPSDT process. Dental screenings are covered for any child under the age of twenty-one (21) years per the recommended guidelines set forth by the American Academy of Pediatric Dentistry (AAPD) and Bright Futures.

### **10.6 Continuity of Care for MCO Orthodontic Services**

The MCO's reimbursement for children's orthodontic services must cover the entire duration of treatment.

### **10.7 Continued Care for Active Orthodontia**

The MCO must ensure, in conjunction with DHHR, continuity of care for active orthodontia cases until care is completed and providers are fully reimbursed. The MCO must pay for orthodontic services not previously reimbursed under the FFS as a part of the global payment fee.

The MCO must allow an enrollee to continue receiving orthodontic services with an existing out-of-network provider.

The MCO must maintain written orthodontic continuity of care records.

## **11. BEHAVIORAL HEALTH SERVICES**

### **11.1 MCO Behavioral Services Administration**

The MCO must provide inpatient and outpatient behavioral services as covered services in an amount, duration, and scope reasonably expected to achieve the purpose for which the services are furnished.<sup>18</sup> The benefit must be provided in accordance with 42 CFR Subpart K, Parity in Mental Health and SUD Benefits. The MCO must develop and maintain an ongoing Mental Health Parity Compliance Plan to be submitted to the Department annually by June 30<sup>th</sup>. The MCO is not subject to implementation of parity requirement associated with quantitative treatment limits of prescription drugs, as this benefit is administered under FFS.

The MCO may place appropriate limits on a service on the basis of such criteria as medical necessity or utilization control, consistent with the terms of this Contract and clinical guidelines. The MCO may not impose an aggregate lifetime, annual dollar limits, or other cumulative financial limits on mental health or SUD services.

The MCO may employ the services of a Subcontractor serving as a behavioral health benefit administrator or utilization review agent if such administrator or agent covers the behavioral health benefit equivalent to the requirements described in Appendix A and in accordance with this contract. If the MCO elects to employ the services of a benefit manager or utilization review

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<sup>18</sup> 42 CFR § 438.210

agent, the MCO is required to comply with all Subcontractor requirements outlined in this contract.

A mental health screening shall be completed for any child not already known to be receiving mental health services. The MCO shall provide mental health screenings and services when the child enters Youth Services, the child welfare system, and upon the request of the family, foster family, or kinship care family. The MCO shall provide a quarterly report of all approved and denied mental health screenings and services. Failure to complete a mental health screening for any child not currently receiving mental health services shall result in a liquidated damage, as defined within Appendix F.

### **11.2 Behavioral Health Director**

The MCO must employ or Contract with a qualified West Virginia licensed physician to serve as the Behavioral Health Director for the covered behavioral services. When employed or contracted, the Behavioral Director must be available for behavioral utilization review decisions and must be authorized and empowered to respond to behavioral clinical issues, utilization review, and behavioral quality of care inquiries.

### **11.3 Behavioral Health Covered Services**

The MCO covered behavioral services must be rendered by providers within the scope of their license and in accordance with all State and Federal requirements. Behavioral services include: mental health outpatient services, mental health inpatient services, SUD outpatient services (including but not limited to pharmacologic management and including methadone treatment), targeted case management, behavioral health rehabilitation and clinic services, psychiatric residential treatment services, and all SUD treatment services provided under the Department's 1115 SUD waiver. The MCO must follow DHHR FFS policies contained in Chapter 529 of the WV Medicaid Provider Manual for drug screening services.

### **11.4 Coordination of Care**

Notwithstanding internal care coordination of care requirements outlined in Article III, Section 6.3 of this Contract, the MCO's primary care provider must coordinate the enrollee's health services, as appropriate, with behavioral health providers.

The MCO must initiate care coordination services for enrollees being discharged from crisis stabilization units.

If an enrollee is identified as having a dependence disorder including alcohol, opiate, amphetamine, benzodiazepine, or poly substance, and in need of engagement of treatment, the MCO must assign the enrollee a MCO Care Coordinator, at a minimum, through the duration of the treatment process.

### **11.5 Adult Inpatient and Residential Care for Behavioral Health**

Article III, 8.6.1, Responsibility for Inpatient Care, does not apply to the behavioral inpatient and residential care services. Payment liability for behavioral health inpatient services is assigned as follows:

- The MCO is not responsible for any payments for inpatient behavioral health services that are covered by FFS;
- The MCO is responsible for all claims incurred within the inpatient behavioral health treatment settings covered by managed care;
- The MCO is not responsible for claims incurred within the inpatient behavioral health or residential treatment setting if an enrollee entered the treatment setting as an FFS enrollee;
- The MCO is not responsible for claims incurred within the inpatient behavioral health treatment settings if an enrollee entered the treatment setting as an enrollee of another MCO;
- The MCO is not responsible for any claims incurred during residential treatment facility stay for individuals twenty-one (21) years of age or older;
- Notwithstanding any of the provisions of Article III, Section 11.5, the MCO is responsible for any claims incurred during involuntary inpatient facility stay.

#### **11.6 Children's Inpatient Care for Behavioral Health**

- The MCO is not responsible for any payments for inpatient behavioral health services that are covered by FFS;
- The MCO is responsible for all claims incurred within the inpatient behavioral health or psychiatric treatment settings covered by managed care;
- The MCO is not responsible for claims incurred within the inpatient behavioral health or psychiatric treatment setting if an enrollee entered the treatment setting as an FFS enrollee; and
- The MCO is not responsible for claims incurred within the inpatient behavioral health or psychiatric treatment settings if an enrollee entered the treatment setting as an enrollee of another MCO.

#### **11.7 Court Ordered Services**

If any court issues an order for services to a West Virginia Medicaid MCO enrollee or orders West Virginia Medicaid, the State of West Virginia, any West Virginia agency, the MCO, or any other entity under the auspices of Medicaid, to pay for medical services for one (1) of the MCO's Medicaid enrollees, including children's residential treatment services, the MCO must comply with the court order and pay for the services. To encourage the use of the most appropriate treatment options for the child, the MCO must establish an approach of informing the court of alternative services that would best meet the needs of the child.

#### **11.8 Behavioral Health Provider Network**

The MCO must comply with this Section notwithstanding Article III, Section 3 of this Contract.

The MCO must reimburse at least one hundred percent (100%) of the current FFS Medicaid fee schedule to in-network behavioral health provider, unless such provider agreed to an alternative payment schedule. The Department will notify the MCO of any changes in the FFS Medicaid

schedule as soon as administratively possible. The MCO must adjust the reimbursement schedule to in-network behavioral provider within thirty (30) calendar days of the Department's notification of any changes in the FFS Medicaid schedule.

### **11.9 Behavioral Health Service Authorization**

In addition to the service authorization requirements outlined in Article III, Section 6.4, the MCO must utilize the Department's standard behavioral service authorization format or other authorization format approved by the contracted provider.

Partial hospitalization programs must be approved by the Department before the MCO may offer the services to its enrollees by that provider.

### **11.10 Substance Use Disorder (SUD) Services**

#### ***11.10.1 General Requirements***

In response to the opioid epidemic in West Virginia, the Department seeks to enhance available SUD prevention and treatment services available to Medicaid enrollees.

#### ***11.10.2 SUD 1115 Demonstration Waiver***

Building on legislative and health systems activities, the goal is to create a seamless continuum of care to support enrollees in their recovery. The MCO is expected to support the following goals:

- Improve quality of care and population health outcomes for Medicaid enrollees with SUD;
- Increase enrollee access to and utilization of appropriate SUD treatment services based on American Society of Addiction Medicine (ASAM®) Criteria;
- Decrease medically inappropriate and avoidable utilization of high-cost emergency department and hospital services by enrollees with SUD;
- Improve care coordination and care transitions for Medicaid enrollees with SUD; and
- Follow the CMS standards and guidelines as stated in the Special Terms and Conditions of the West Virginia approved 1115 SUD Waiver.

The Department has established standards of care for SUD demonstration waiver services that incorporate industry standard benchmarks from the ASAM® Criteria for patient assessment and placement, service, and staffing specifications.

#### ***11.10.3 SUD Services Continuum of Care***

The MCO will be responsible for a seamless continuum of care for SUD treatment to all West Virginia Medicaid enrollees who meet medical necessity criteria for services. These services include standard SUD services authorized under the West Virginia Medicaid State Plan as well as SUD services authorized under West Virginia's SUD 1115 demonstration waiver. The MCO must follow all standards and criteria adopted by the Department regarding SUD services as

outlined in the West Virginia Medicaid Provider Manual, Chapter 504: Substance Use Disorder Services.

*11.10.3.1 Medicaid State Plan SUD services*

Medicaid State Plan SUD services include:

- Targeted Case Management;
- Naloxone Administration Services;
- Screening, Brief Intervention and Referral to Treatment (0.5 ASAM® Level of Care);
- Outpatient Services (1.0 ASAM® Level of Care);
- Intensive Outpatient Services (2.1 ASAM® Level of Care);
- Partial Hospitalization Services (2.5 ASAM® Level of Care);
- Medically Monitored Intensive Inpatient Services (3.7 ASAM® Level of Care);
- Medically Managed Intensive Inpatient Services (4.0 ASAM® Level of Care);
- Ambulatory Withdrawal Management Services (1-WM & 2-WM ASAM® Level of Care);
- Medically Monitored Inpatient Withdrawal Management Services (3.7-WM ASAM® Level of Care); and
- Non-Methadone Medication Assisted Treatment (MAT).

*11.10.3.2 SUD 1115 Demonstration Waiver Services*

SUD 1115 demonstration waiver services include:

- Peer Recovery Support Services (1.0 ASAM® Level of Care);
- Clinically Managed Low Intensity Residential Services (3.1 ASAM® Level of Care);
- Clinically Managed Population-Specific High Intensity Residential Services (3.3 ASAM® Level of Care);
- Clinically Managed High Intensity Residential Services (3.5 ASAM® Level of Care); and
- Clinically Managed Residential Withdrawal Management Services (3.2-WM ASAM® Level of Care).

Opioid Treatment Program services (methadone only) included in the SUD waiver will be provided through Medicaid FFS. The MCO will be responsible for assisting an enrollee during the admission and discharge transition process for Opioid Treatment Program services.

#### *11.10.3.3 Peer Recovery Support Services*

Peer recovery support services are designed and delivered by individuals called Peer Recovery Support Specialists who are in recovery from SUD. These Peer Recovery Support Specialists provide counseling support to help prevent relapse and promote recovery. Services must be provided by appropriately trained staff when working under the supervision of a competent behavioral health professional, as defined by the State. A Peer Recovery Support Specialist must be certified as outlined in the West Virginia Medicaid Provider Manual, Chapter 504. The West Virginia Department-approved training program provides Peer Recovery Support Specialists with a basic set of competencies necessary to perform the peer support function. The Peer Recovery Support Specialist must demonstrate the ability to support the recovery of others from SUD. Similar to other provider types, ongoing continuing educational requirements for Peer Recovery Support Specialists must be in place.

#### *11.10.3.4 SUD Residential Treatment Services*

Treatment services delivered to residents of an institutional care setting, including facilities that meet the definition of an IMD, are provided to West Virginia Medicaid enrollees with an SUD diagnosis when determined to be medically necessary by the MCO's utilization staff and in accordance with an individualized service plan (ISP). The MCO's utilization staff, physicians, or Medical Directors will perform independent reviews of assessments to determine the level of care and length of stay recommendations based upon the ASAM® multidimensional assessment criteria.

- Residential treatment services must be provided in a BMS-certified facility that has been enrolled as a Medicaid provider and has been assessed by the Department as delivering care consistent with ASAM® Levels 3.1, 3.3, 3.5, and/or 3.7.
- The BMS-certified facility must be credentialed and enrolled by an MCO as a network provider. Each residential treatment provider will be certified as meeting the provider and service specifications described in the West Virginia Medicaid Provider Manual, Chapter 504 consistent with the ASAM® criteria for the requisite level or sublevel of care prior to participating in the West Virginia Medicaid program under the SUD 1115 demonstration waiver. The MCOs will provide credentialing for ASAM® Levels 3.1, 3.3, 3.5 and/or 3.7 contingent on the providers receiving certification from the state.
- Residential treatment services can be provided in settings of any size.
- Room and board costs are not considered allowable costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

Covered Residential Treatment services include:

- Clinically-directed therapeutic treatment to facilitate recovery skills, relapse prevention, and emotional coping strategies;
- Addiction pharmacotherapy and drug screening;
- Motivational enhancement and engagement strategies;

- Counseling and clinical monitoring;
- Withdrawal management and related treatment designed to alleviate acute emotional, behavioral, cognitive, or biomedical distress resulting from or occurring with an individual's use of alcohol and other drugs;
- Regular monitoring of the individual's medication adherence;
- Recovery support services;
- Counseling services involving the beneficiary's family and significant others to advance the beneficiary's treatment goals, when (1) the counseling with the family member and significant others is for the direct benefit of the beneficiary, (2) the counseling is not aimed at addressing treatment needs of the beneficiary's family or significant others, and (3) the beneficiary is present except when it is clinically appropriate for the beneficiary to be absent in order to advance the beneficiary's treatment goals; and
- Education on benefits of MAT and referral to treatment as necessary.

#### **11.10.4 Use of ASAM® Criteria**

The MCO and all SUD providers are required to incorporate the national patient assessment and placement guidelines as established in the ASAM® Criteria, into current assessment and level of care determination processes. The multidimensional assessment framework will be implemented as a standard component of the bio-psychosocial assessment and level of care determination process.

#### **11.10.5 SUD Provider Certification, Credentialing, and Network**

The Department's ASO contractor for the SUD waiver will complete the SUD provider certification process and provide a report to the Department. Final certification letters will be sent out by the Department and the MCO will be notified of the certified providers by the Department.

Contingent on the SUD providers receiving certification from the state, the MCO will credential all SUD providers consistent with the key benchmarks from ASAM® Criteria as set forth in the Medicaid Provider Manual, Chapter 504.

The MCO must meet the SUD provider network standards as outlined in Appendix K.

#### **11.10.6 SUD Provider Training and Education Requirements**

SUD providers are responsible for providing training and education to their staff on the ASAM® Level of Care criteria and the application of the ASAM® Criteria in the assessment process. During provider enrollment, the MCO will obtain attestation from the SUD provider that ASAM® Criteria will be applied appropriately by the provider's SUD program staff. As part of the Department's quality monitoring strategy, personnel and clinical records of a sample of the provider network will be reviewed to evaluate if there is appropriate application of and fidelity to the ASAM® Levels of Care and the Medicaid Provider Manual. The Department's ASO contractor for the SUD waiver will perform these retro reviews of providers to ensure SUD

program providers are consistently applying ASAM® Criteria throughout an individual's stay and that documentation and personnel records meet established Medicaid standards.

#### **11.10.7 SUD Reporting Requirements**

The MCO must comply with all monitoring and evaluation requirements of the SUD waiver.

#### **11.11 Serious Emotional Disorder (SED) Waiver Services**

The Serious Emotional Disorder (SED) is a §1915(c) Medicaid HCBS waiver that provides additional HCBS beyond what is covered under the state's Medicaid State Plan. The SED waiver permits the Department to provide an array of HCBS that enable children who would otherwise require institutionalization to remain in their homes and communities. In addition, it is anticipated that this waiver will reduce the number of children housed both in-state and out-of-state in PRTFs and shorten the lengths of stay for children who require acute care.

The MCO is expected to contract with all CSEDW approved providers within the State, and will also be required to implement solutions (e.g., Non-Emergency Medical Transportation) to assist members in accessing necessary providers if there is a network gap in certain areas. The MCO will also be required to perform prospective member forecasting, in accordance with the CSEDW enrollment requirements, to ensure that the MCO's network is continually sufficient to meet the access needs of the population.

##### **11.11.1 SED HCBS Waiver Eligibility**

To be eligible for the waiver children must be at least three (3) years old and under twenty-one (21) and currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Disease (ICD) equivalent that is current at the date of evaluation. The evaluation must state that the SED has resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, and/or community activities.

The Department will contract with an ASO and psychological practice to serve as the Medical Eligibility Contracted Agent (MECA) to determine SED waiver eligibility and manage allotted waiver slots and enrollment into the MCO.

##### **11.11.2 Person Centered Service Plan Team (PCSPT)**

The MCO must ensure that each child eligible and enrolled in the MCO through the SED waiver will have a Person-Centered Service Plan Team (PCSPT) to develop measurable outcomes that guide the child or youth toward less intensive services and transition or graduation from the waiver.

During the initial PCSPT meeting, the child's case manager in conjunction with the PCSPT informs the child and the parents/caregivers/legal representatives of the child of the available resources that may be included in the Person-Centered Service Plan (PCSP). SED waiver services will emphasize the importance of combining natural supports from the community with professionals to create a PCSP that supports the successful treatment of the member and the parents/caregivers/legal representatives of the child. The PCSPT consists of the child and/or

parent/caregiver/legal representative of the child, the child's case manager, representatives of each professional discipline, provider and/or program providing services to the child (inter- and intra-agency), and MCO care coordinator (if requested).

The MCO will be required to provide intensive care coordination services, including follow-up and interfacing with the child's provider and medical record reviews from the provider. These activities can also be discussed during the members' Person-Centered Service Plan Team (PCPST) to ensure that appropriate services are being provided after a member's discharge from an inpatient setting.

#### *11.11.2.1 Role of the Case Manager*

The MCO will ensure a case manager is assigned to each child eligible and enrolled in the MCO through the SED waiver. As a safeguard, case management services cannot be provided by the same agency providing any other SED waiver or Medicaid State plan service to the child. SED waiver providers will be categorized by type of services offered (i.e. case management) and enrollees may choose their individual providers for each category. Enrollees may change SED waiver providers at any time with the transfer becoming effective the first day of the month following the request. The child and their parent/caregiver/legal representative will complete a Freedom of Choice form, choosing their case management agency.

The case manager is responsible for engaging the child and the child's family in a partnership of shared decision-making regarding the development and implementation of the child's individual PCSP throughout the child's enrollment in MCO. The PCSP must be based upon person-centered philosophy and is the key document that combines all information from the evaluations to guide the service delivery process as well as information from people who know the child outside the service delivery system. Evaluations include any significant medical, physical therapy, occupational therapy, speech therapy, nutritional, nursing evaluations, and behavior support evaluations in addition to an initial functional assessment administered by the MECA and annual reevaluation by the ASO. The development of the PCSP by the PCSPT must be guided by the member's needs and goals as well as address the needs that are identified in assessments and evaluations.

The case manager is responsible for scheduling and coordinating PCSPT meetings, monitoring the implementation of the PCSP, for initiating PCSPT meetings as the needs of the child dictate. It is important to remember that, although coordination of the PCSP process is the responsibility of the case manager, development of the PCSP is the responsibility of the PCSPT. Participation of the PCSPT is expected to ensure the process is person-centered.

The Department utilizes the strengths model, which views the child and parent/caregiver/legal representative of the child as the expert on the strengths and needs of the child. These strengths and needs are then used to guide PCSP development in combination with the information gathered during the intake. The PCSPT captures the strengths, needs, preferences, and desired outcomes of the child and decides frequency and duration of services and supports. The case manager is responsible for ensuring that service providers implement the content of the PCSP.

PCSPT meetings must be scheduled at times and places that facilitate the inclusion of the child and parent/caregiver/legal representative of the child. The child and parent/caregiver/legal representative of the child have the ability to request a meeting of their PCSPT at any time should needs or circumstances change. The child and parents/caregivers/legal representatives of the child determine their level of participation in the PCSP development, the identification of PCSP goals, and the designation of PCSP services and supports.

The case manager is responsible for facilitating the development of and the subsequent updates to the PCSP document. The PCSP must be updated every ninety (90) days or sooner in the case of critical treatment junctures to reflect the child's progress or barriers related to his/her identified treatment plan goals and objectives and reviewed by the PCSPT.

Once the child's PCSP is developed, the case manager ensures and coordinates a comprehensive set of supports, resources and strategies for each child and family based on the child's PCSP. S/he works closely with service providers to assure that SED waiver services and clinical treatment modalities augment each other for optimal outcomes for members and parents/caregivers/legal representatives.

The case manager also works with the Department's ASO for the SED waiver to schedule the child's annual assessment needed to make an annual determination as to whether or not the child continues to be eligible for the waiver and enrolled in the MCO.

Finally, the case manager will lead the PCSPT through development and implementation of a transition plan for youth who will reach the SED waiver's maximum age limit. Beginning around the time the child turns fifteen (15), the PCSPT's focus will be on planning for transition including housing, employment, vocational training or school status, emotional/behavioral health, physical health, and safety. The team will focus on enhancing skills utilizing Medicaid State Plan and waiver services, as well as by helping the youth and family identify and understand what services may be available post-waiver. If the youth's disability impacts his/her ability to earn income, the team will work with the youth to apply for Supplemental Security Income (SSI) benefits at age 18. The PCSPT will also work with the youth to identify other entitlements that would assist the youth post-waiver. This is also the time during which the team will explore what mental health needs the youth may have after his/her<sup>2</sup>1st birthday and start that transition process with adult services. Whenever possible, the adult services staff will be encouraged to become part of the PCSPT to assure a smooth transition to adult services.

#### *11.11.2.2 Person Centered Service Plan (PCSP) Timeline*

A case manager with the chosen case management agency will contact the child and parent/caregiver/legal representative to begin engagement in the PCSP development process prior to the seven (7) day meeting taking place. During this contact, the case manager assures the delivery of the SED enrollment information describing the waiver services, free choice of providers, and how to report abuse and neglect.

Within seven (7) days of the SED waiver intake, a mutually agreed upon date will be set for the initial PCSPT meeting. The Case Manager will also schedule and administer the CANS

instrument for use in development of the annual PCSP. Although the Case Manager should begin administration of the CANS instrument at the seven (7) day meeting, the expectation is that the CANS will be completed within thirty (30) days of intake to assist with PCSP development. The PCSP shall be developed within seven (7) days and completed within thirty (30) days of intake. The signed PCSP shall be distributed to all members of the PCSPT within fourteen (14) calendar days.

The case manager shall ensure that a six (6) month PCSP review is completed. If at the child's six (6) month PCSP review, the PCSPT determines he/she has not benefited from waiver enrollment (i.e. no progress has been made on the child's treatment goals and objects), then the PCSPT will refer the child to the ASO to re-determine level-of-care (LOC) placement. Likewise, the PCSPT may determine the child has benefited from waiver enrollment and no longer requires services delivered by this program, at which time discharge planning will commence. Every person must have a re-determination of medical eligibility completed at least annually. The anchor date of the member's annual re-determination is the first day of the month after the initial medical eligibility was established by the MECA. If the reevaluation results in a denial of waiver eligibility, the final decision will be made by BMS.

The MCO shall be responsible for ensuring that the case manager with the case management agency has developed and submitted to the MCO a Person-Centered Service Plan (PCSP) for each SED member. The MCO shall be responsible for reviewing the ISP prior to service authorization for specified services to ensure appropriateness based on the needs of the child, and in compliance with Chapter 502 of the BMS Provider Manual.

The case manager shall also be responsible for development of a back-up plan for service plans, including the authorization process, in the event a member is unable to access services through the defined primary channel. The MCO must determine whether the back-up plan is sufficient in meeting the needs of the member should it need to be activated and collaborate with the case manager if insufficient.

#### ***11.11.3 Additional Home and Community-Based Services (HCBS)***

As appropriate, children enrolled in the Specialized Managed Care Plan for Children and Youth as a result of eligibility for the SED waiver may receive any of the Medicaid State Plan services and additional SED waiver services identified in Appendix A as appropriate to meet the child's individual needs, and as defined within Chapter 502 of the BMS Policy Manual.

#### ***11.11.4 SED Reporting Requirements***

The MCO must comply with all monitoring and evaluation requirements of the SED waiver, and associated BMS Policy, Chapter 502.

The MCO must comply with the requirements of the WV CSED HCBS Waiver Incident Reporting Guide (IRG). Critical incidents are serious in nature and pose immediate risk to the health, safety, or welfare of the member or others. These incidents require in-depth investigation, an expedited timeline, and possibly additional resources.

The MCO must:

- Develop and maintain policies and procedures to review and track critical incidents and determine whether they represent a single incident or a pattern of incidents with the Direct Service Provider (DSP)
- Develop and maintain internal incident management system to track critical incidents
- Provide information and resources to all members in the Member Handbook and on the MCO website on how to identify, prevent, and report instances of potential abuse, neglect, or exploitation
- Receive provider's report of critical incident as soon as possible and within 24 hours of witnessing or discovering the incident
- Monitor providers' investigations to help ensure they are initiated within 24 hours of the provider learning of the event and that the completed report is entered into the MCO IMS
- For suspected abuse and/or neglect, verify that provider has made report to APS for members over the age of 18 and CPS for members under the age of 18
- Regularly review and analyze incident reports to identify trends regarding members' health and safety and trends regarding provider agencies
- Inform BMS promptly of any concerns regarding provider agencies and MCO's recommendations and gain support for next steps
- Analyze claims data for children served under the waiver and compare the information in the claims with the incident reporting from each DSP. If there are any serious incidents that were not reported, investigate further to determine if the DSP failed to report an incident. Take action with the DSP to address any failures to report.
- Generate monthly report for BMS of reported allegations of abuse and/or neglect, critical and non-critical incidents, and completed investigations submitted through the MCO IMS, including actions taken to ameliorate the situation and assure the health and safety of children served by the DSP.
- Generate quarterly incident summary reports for BMS Quarterly Improvement Advisory (QIA) Council
- Regularly review and analyze incident reports to identify trends and report such trends to BMS.
- **Identified incidents must be reported to BMS within 24 hours of occurrence.**

11.11.5 In addition, the MCO is required to monitor, collect and report data on all performance measures as defined by the CSED waiver. The MCO will be required to report on authorizations through a weekly dashboard report, delineating specific service types and authorization approvals, denials, and reductions. This report will

occur weekly through the first 90 days of operations, and will occur on a monthly basis thereafter

#### SED Provider Networks

The MCO will be required to interface and outreach with all CSEDW approved providers and determine their panel and/or capacity for new patients on a monthly basis. The MCO's contracting efforts will include assurances that providers have appropriate and adequate panel capacity. The MCO will be required to monitor their provider network on a monthly basis for 6 months after go-live, and on a quarterly basis thereafter.

The MCO is expected to contract with all CSEDW approved providers within the State, and will also be required to implement solutions (e.g., Non-Emergency Medical Transportation) to assist members in accessing necessary providers if there is a network gap in certain areas. The MCO will also be required to perform prospective member forecasting, in accordance with the CSEDW enrollment requirements, to ensure that the MCO's network is continually sufficient to meet the access needs of the population. The MCO will also be required to perform intensive care coordination efforts to work with their provider network to ensure that members have access at the right time for applicable providers.

The MCO will be required to maintain a roster of available providers who are accepting patients, and will be required to perform care coordination services to connect members to available providers within the 7-day timeframe from discharge of an inpatient stay or crisis situation. If the MCO cannot identify available providers within the State, they will be required to provide NEMT and develop ad hoc contracting situations (e.g., Single Case Agreements) with bordering State providers, as necessary. The MCO will also be expected to continue and/or approve authorizations from out of network providers to promote care continuity, in the event that the MCO's current provider network cannot support the service. The MCO is required to coordinate care such that no child should have to wait longer than two (2) weeks for a standard appointment.

The MCO will be required to provide intensive care coordination services, including follow-up and interfacing with the child's provider and medical record reviews from the provider. These activities can also be discussed during the members' Person-Centered Service Plan Team (PCPST) to ensure that appropriate services are being provided after a member's discharge from an inpatient setting.

## **12 SOCIALLY NECESSARY SERVICES (SNS)**

The MCO is responsible for serving as an ASO for the delivery of SNS under this contract as defined by BCF and outlined within the Department's SNS Utilization Management Manual.

### **12.1 Contracting**

The Department shall retain authority for screening, enrollment and contracting with SNS providers to administer services for youth. The MCO must allow for the authorization of services to any provider approved by BCF. BCF shall provide a monthly enrollment report of all qualified providers permitted to serve enrollees as a validation tool by which to authorize services.

## **12.2 Invoicing**

Invoicing shall remain the responsibility of BCF. The provider must continue to submit invoices directly to BCF for payment. The MCO must assist the provider with validating any information needed for invoicing purposes by providing information as needed (e.g. total authorized units of a service for the month) upon request of the provider. The MCO must provide such information back to the provider within three (3) calendar days.

## **12.3 Reporting**

The MCO must collect a monthly progress report from the provider for each family served by the 10<sup>th</sup> day of each month. This document is the same as that to be submitted to the Department. Providers of home studies, clinical reviews and Clinician Administered PTSD Scale (CAPS) reports are not required to submit monthly progress reports, but may only submit their invoice once the home study, clinical review or CAPS report has been provided to the CPS caseworker. The MCO must coordinate with the CPS caseworker and BCF to determine if this deliverable has been met so the Department may issue payment.

The MCO must report monthly to the Department on underserved areas of the State where they believe additional SNS providers should be permitted to enroll to address a gap in care.

## **12.4 Retrospective Reviews**

The MCO must administer retrospective reviews of the SNS providers. Any such review must be conducted within three (3) years of the term of the BCF agreement with the provider. Providers must score at least eighty (80) percent during their retrospective review for each service reviewed. Providers failing to meet eighty (80) percent will be placed on a probation period for each respective service failing to meet that threshold. The MCO must provide a written notice that the probation period is in effect. At the end of the probation period, the MCO must conduct another assessment. If the provider continues to score less than eighty (80) percent for that service, the service will be closed for that provider and the provider will no longer be eligible for referrals for that service. If the provider scores a zero (0) on any safety related service during any review, the service will be automatically closed for the provider.

The MCO must provide a report on each provider assessment to BCF outlining the results of each of the services under review, the methodology by which the provider was reviewed, the scores for each service area, provider strengths, weaknesses (opportunities for improvement), documentation that all staff have met background check, licensure and educational requirements, as applicable, and recommendations for next steps to improve provider processes. BCF shall take appropriate action to provider contracts based on the feedback submitted by the MCO. The MCO must provide its reports to BCF within thirty (30) calendar days of completion of the assessment and must coordinate with BCF throughout the process to expedite any necessary action.

The MCO must continuously monitor the utilization of services and provide monthly reports, due fifteen (15) days after the conclusion of the month, that highlight geographic areas in which there is a high utilization of services required with low provider enrollment (e.g. providers must travel greater than forty-five (45) minutes to render services) or the use of providers that are not most geographically appropriate in the requested service area. The report must provide recommendations to BCF on how to address such service gaps and misutilization of providers.

## **12.5 Authorization Requirements**

The MCO must establish a bidirectional IT solution by which the MCO can receive SNS authorization requests entered by the CPS caseworker into the State's FACTS system and return authorization approvals. The MCO must authorize services entered into the system within forty-eight (48) hours of entry for those authorized automatically. Those services that require care management review must be returned within five business days of receipt of all additional necessary information from the provider. The MCO must not require authorization for emergency services. The CPS caseworker shall retain the authority to select the vendor to be used for SNS, however, the MCO must be available to assist the worker with identification of a provider, if needed.

The MCO must authorize the services for the scope and duration of the request by the CPS caseworker, as appropriate, and may reauthorize services pending review of progress by the enrollee. In the event the duration of services is not outlined within the request, the MCO must coordinate with the CPS caseworker to determine the most appropriate level of service for the initial authorization. During contract year one (1), the MCO must utilize the existing BCF Utilization Management Manual for its authorization review process.

The MCO must also establish a provider portal by which the provider may review their authorizations to determine the scope and duration of services authorized by the MCO. Authorization information must be uploaded within twenty-four (24) hours of approval. In contract year one (1), the provider portal must replicate the elements of the existing provider tool for accessing referrals, requesting additional services, and meeting other provider needs. The MCO may develop its own system in parallel for implementation in future contract periods.

## **12.6 Focus Groups**

The MCO must conduct at least twelve (12) focus groups throughout the year with youth, families and foster parents that reside in the community and utilize SNS. The focus groups should be used as an opportunity to provide the Department with feedback on where services are being most impactful, so programmatic changes may be made to improve the overall health of the program. The focus groups must target, at a minimum, the following six (6) areas:

1. Access
2. Service Delivery
3. Gaps in Support Systems
4. Engagement with System Staff
5. Cultural Competency
6. Consumer Knowledge of Services and Supports

The MCO must collaborate with BCF on the questions to be used in the focus groups to ensure the most useful information is being collected. A sample template of questions is located in Appendix J.

## **13. CHILDREN'S RESIDENTIAL TREATMENT FACILITIES/EMERGENCY SHELTERS**

### **13.1 Provider Network**

The MCO is required to make all reasonable efforts to contract with all currently enrolled residential treatment facilities. The State shall define for the MCO the category by which each facility falls in alignment with FFPSA.

### **13.2 Qualified Residential Treatment Program (QRTP)**

A QRTP must be a program that:

- Has a trauma-informed treatment model that is designed to address the needs, including clinical needs as appropriate, of children with serious emotional or behavioral disorders or disturbances and, with respect to a child, is able to implement the treatment identified for the child by the required thirty (30) day assessment (described below) of the appropriateness of the QRTP placement;
- To extent appropriate, and in accordance with the child's best interests, facilitates participation of family members in the child's treatment program;
- Facilitates outreach to the family members of the child, including siblings, documents how the outreach is made (including contact information), and maintains contact information for any known biological family and fictive kin of the child;
- Documents how family members are integrated into the treatment process for the child, including post-discharge, and how sibling connections are maintained;
- Provides discharge planning and family-based aftercare support for at least 6 months post-discharge; and
- Is licensed in accordance with the title IV-E requirements (section 471(a)(10) of the Social Security Act) and is accredited by any of the following independent, not-for-profit organizations: The Commission on Accreditation of Rehabilitation Facilities (CARF), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Council on Accreditation (COA), or any other independent, not-for-profit accrediting organization approved by HHS; and
- Has registered or licensed nursing staff and other licensed clinical staff who provide care within the scope of their practice as defined by state/tribal law, are on-site according to the treatment model, and are available twenty-four (24) hours a day and seven (7) days a week. This requirement must not be construed as requiring a QRTP to acquire nursing and behavioral health staff solely through means of a direct employer to employee relationship.

#### ***13.2.1 QRTP Placement Assessment***

The MCO must ensure an independent assessment of the QRTP placement is completed within thirty (30) days after placement in the QRTP. A "qualified individual" must assess a child to determine the appropriateness of a placement in a QRTP within thirty (30) days after the placement is made for purposes of approving the case plan and the case system review procedure

for the child (section 475A(c) of the Social Security Act). A “qualified individual” is defined as a trained professional or licensed clinician who is not an employee of the agency, and who is not connected to, or affiliated with, any placement setting in which children are placed by the agency.

The “qualified individual” must:

- Assess the strengths and needs of the child using an age-appropriate, evidence based, validated, functional assessment tool approved by the Secretary;
- Determine whether the needs of the child can be met with family members or through placement in a foster family home or, if not, which allowable Child Care Institution (CCI) setting would provide the most effective and appropriate level of care for the child in the least restrictive environment and be consistent with the short- and long-term goals for the child, as specified in the permanency plan for the child;
- Develop a list of child-specific short- and long-term mental and behavioral health goals; and
- Work in conjunction with the child’s family and permanency team (further described below) while conducting and making the required thirty (30) day assessment.

If the “qualified individual” determines the child should not be placed in a foster family home, he/she must specify in writing:

- The reasons why the child’s needs can’t be met by the family or in a foster family home (a shortage of foster family homes is not an acceptable reason for determining the child’s needs cannot be met in a foster family home); and
- Why the recommended placement in a QRTP is the setting that will provide the child with the most effective and appropriate level of care in the least restrictive environment and how that placement is consistent with the short- and long-term goals for the child, as specified in the permanency plan for the child (section 75A(c)(1) of the Social Security Act).

### **13.2.2 QRTP Court Review**

Within sixty (60) days of the start of each placement in a QRTP, a family or juvenile court or another court (including a tribal court) of competent jurisdiction, or an administrative body appointed or approved by the court, independently, must:

- Consider the required thirty (30) day assessment of the appropriateness of the QRTP, and documentation made by the qualified individual conducting the assessment;
- Determine whether the needs of the child can be met through placement in a foster family home or, if not, whether placement of the child in a QRTP provides the most effective and appropriate level of care for the child in the least restrictive environment and whether that placement is consistent with the short- and long-term goals for the child, as specified in the permanency plan for the child; and

- Approve or disapprove the placement. Such approval or disapproval must be documented in the case plan (section 475A(c)(2) of the Social Security Act).

The MCO is required to work with the court system as needed to complete the review and ensure coordination of the child's care if transitioned to a different placement.

### ***13.2.3 Other FFSPA Requirements***

The MCO must have procedures in place to ensure that foster children are not inappropriately diagnosed with mental and behavioral health disorders, medical fragility or developmental disabilities for the sole purpose of procuring a placement in a non-family setting such as a residential facility or hospital.

If a title IV-E agency places a child in a QRTP for more than 12 consecutive months, or 18 nonconsecutive months, or, in the case of a child who has not attained age 13, for more than six consecutive or nonconsecutive months, the title IV-E agency must submit to HHS:

- the most recent versions of the evidence and documentation submitted for the most recent status review or permanency hearing; and
- the signed approval of the head of the title IV-E agency for the continued placement of the child in that setting

The MCO shall be responsible for providing to BCF any data necessary for completion of this report.

### **13.3 Focus Groups**

The MCO must conduct at least twelve (12) focus groups throughout the year with youth, families and foster parents that have received services within a residential treatment facility. The focus groups should be used as an opportunity to provide the Department with feedback on where services are being most impactful, so programmatic changes may be made to improve the overall health of the program. The focus groups must target, at a minimum, the following six (6) areas:

1. Access
2. Service Delivery
3. Gaps in Support Systems
4. Engagement with System Staff
5. Cultural Competency
6. Consumer Knowledge of Services and Supports

The MCO must collaborate with the BCF on the questions to be used in the focus groups to ensure the most useful information is being collected.

### **13.4 Provider Requirements**

The MCO must ensure that Children's Residential Treatment Facilities and Emergency Shelters adhere to the requirements of their contract with BCF through collaboration with DHHR of this oversight. The MCO must monitor and validate that all services, referral standards, admission standards, discharge standards, personal needs of youth, medical service requirements, and reporting requirements are adhered to. Standards for both residential providers and emergency shelter providers are outlined within the BCF Provider Agreements.

### **14. PERSONAL CARE SERVICES**

The MCO is not required to cover personal care services for enrollees. These services will remain covered under fee-for-service.

### **15. COMMUNITY ENGAGEMENT REQUIREMENTS**

The MCO is required to create a voluntary advisory group of foster, adoptive, and kinship parents, which must meet every quarter for the first year and then every six (6) months thereafter, to discuss issues they are encountering with the MCO and recommend solutions. The MCO must report to the Department as requested on the recommendations of the advisory group and address how and why procedures have or have not changed based on those recommendations. This report must be submitted by the Department to the Secretary and the Legislative Oversight Commission on Health and Human Resources Accountability and the public in a timely fashion and must be available on the MCO's Specialized Managed Care Plan for Children and Youth website.

The MCO must establish and maintain a statewide uniform reporting system to collect and analyze data relating to complaints for the purpose of identifying and resolving significant problems faced by foster children and foster parents as a class. The data must be submitted to the BCF within DHHR and the Legislative Oversight Commission on Health and Human Resources Accountability on a quarterly basis.

The MCO shall develop a policy for training new foster or kinship families about the child's medical needs, and assist them with coordinating care for the child as part of care management responsibilities.

### **16. DELEGATION**

The MCO oversees and is accountable for any functions or responsibilities that are described in this Contract that are delegated to other entities; and must have in place policies and procedures for effectively assigning and monitoring activities to those entities. All delegated functions must have a written agreement between the MCO and delegated entity, specifying the delegated activities and reporting responsibilities of the entity and providing for revocation of the delegation or other remedies for inadequate performance. The MCO must evaluate the entity's ability to perform the delegated activities prior to delegation, monitor the entity's performance on an ongoing basis, and formally review performance at least annually. If the MCO identifies deficiencies or areas for improvement, the MCO and the entity must take corrective action. If the MCO delegates selection of providers to another entity, the MCO must retain the right to approve, suspend, or terminate any provider selected by that entity.



## APPENDIX A: DESCRIPTION OF MCO MEDICAL, BEHAVIORAL HEALTH, AND SOCIALLY NECESSARY SERVICES (SNS) COVERED AND EXCLUDED SERVICES

The following charts present an explanation of the medical, behavioral, dental services, and Serious Emotional Disorder (SED) Home and Community Based Services (HCBS) which the MCO is required to provide and SNS delivered through the MCO as an Administrative Services Organization (ASO). However, the Medicaid and BCF State Plans, the SED HCBS waiver, and policy manuals are the final sources for defining these services. The MCO should refer to the Medicaid provider manual and BCF utilization management manual available on the DHHR website for an explanation of service limitations. The MCO must promptly provide or arrange to make available for enrollees all Medically Necessary services listed below and assume financial responsibility for the provision of those services covered by WV Medicaid. Please note that these charts, which list the definitions of services provided under the fee-for-service (FFS) Medicaid program, are provided as a reference for the MCO. The MCO is responsible for determining whether services are Medically or Socially Necessary and whether the MCO will require prior approval for services.

The following charts present the covered services under this contract.

**Table 1: MCO Covered Medical Services**

MEDICAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Ambulatory Surgical Center Services	Any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization, as well as private practitioners.	Nursing, technicians, and related services. Use of the facilities where surgical procedures are performed; drugs, biologicals, surgical dressings, splints, casts, appliances, and equipment directly related to the provision of the surgical procedure; diagnostic or therapeutic services or items directly related to the provision of a surgical procedure. Materials for anesthesia.	Physician services; lab & x-ray; prosthetic devices; ambulance; leg, arm, back, and neck braces; artificial limbs and DME are excluded.
Cardiac Rehabilitation	A comprehensive outpatient program of medical evaluation, prescribed exercise, cardiac risk factor modification, and education and counseling that is designed to restore enrollees with heart disease to active, productive lives. Cardiac rehabilitation can be performed in a specialized, freestanding physician directed clinic or in an outpatient hospital department.	Supervised exercise sessions with continuous electrocardiograph monitoring. The medically necessary frequency and duration of cardiac rehabilitation is determined by the enrollee's level of cardiac risk stratification.	

MEDICAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Children's Residential Services	Services provided by Children's Residential Facility	All children's residential providers and services.	NA
Chiropractor Services	Services provided by a chiropractor consisting of manual manipulation of the spine.	Manipulation to correct subluxation. Radiological examinations related to the service.	Certain procedures may have service limits.
Clinic Services	Preventive, diagnostic, therapeutic, rehabilitative, or palliative services furnished by a clinic (that is not part of a hospital) on an outpatient basis.	General clinics, birthing centers, and health department clinics, including vaccinations for children.	
Early and Periodic Screening, Diagnoses and Treatment (EPSDT)	Early and periodic screening, treatment, and diagnostic services to determine psychological or physical conditions in enrollees under age twenty-one (21). Based on a periodicity schedule. Includes services identified during an interperiodic and/or periodic screen if they are determined to be medically necessary.	Health care, treatment, and other measures to correct or ameliorate any medical or psychological conditions discovered during a screening. A service need not cure a condition in order to be covered under EPSDT. Services that maintain or improve a child's current health condition are also covered in EPSDT because they "ameliorate" a condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. Services are covered when they prevent a condition from worsening or prevent development of additional health problems.	Limited to individuals under age twenty-one (21).
Emergency Shelter Services	Services provided by an emergency shelter provider.	All emergency shelter providers and services.	NA
Family Planning Services & Supplies	Services to aid enrollees of childbearing age to voluntarily control family size or to avoid or delay an initial pregnancy.	All family planning providers, services, and supplies.	Sterilization is not covered for enrollees under age twenty-one (21), for enrollees in institutions, or for those who are mentally incompetent. Hysterectomies and pregnancy terminations are not considered family planning services. Treatment for infertility is not covered.

MEDICAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Handicapped Children's Services/ Children and Youth with Special Health Care Needs Services	Specialty services provided to handicapped children and those who may be at risk of handicapping conditions.	Provides linkage and coordination of services to all WV children with special needs and limited direct medical services, equipment, and supplies to those families that meet financial and other program eligibility requirements.	Services are provided to children under twenty-one (21) with the following diagnoses, but not limited to: cystic fibrosis; myelocystomeningocele/ myelodysplasia; congenital heart defects; craniofacial deformities; seizure disorders; and metabolic disorders.
Home Health Care Services	Nursing services, home health aide services, medical supplies suitable for use in the home.	Provided at the enrollee's place of residence on orders of a physician.	Residence does not include hospital nursing facility, ICF/MR, or state institution. Certain suppliers have service limits.
Hospice	In-home care provided to a terminally ill individual as an alternative to hospitalization.	Nursing care, physician services, medical social services, short-term inpatient care, durable medical equipment, drugs, biologicals, home health aide, and homemaker.	Must have physician certification that enrollee has a life expectancy of six (6) months or less. Enrollees age twenty-one (21) and over waive right to other Medicaid services related to the treatment of terminal illness.
Hospital Services, Inpatient	Hospital services provided for all enrollees on an inpatient basis under the direction of a physician.	All inpatient services, including bariatric surgery, and, corneal transplants.	Excludes those adults in institutions for mental diseases. Excludes behavioral health inpatient stays with a DRG of 425-433 or 521-523 or MS-DRG 880-887 or 894-897. Unlimited medically necessary days based on diagnosis related groups. Transplant services must be in a facility approved as a transplant center by Medicare and prior authorized by Medicaid.
Hospital Services, Outpatient	Medical services furnished on an outpatient basis by a hospital, regardless of the type of provider ordering the service.	Preventive, diagnostic, therapeutic, all emergency services, or rehabilitative medical services.	Services not generally furnished on an inpatient basis by most hospitals in the state. Only technical component of certain services.
Inpatient Rehabilitation	Services related to inpatient facilities that provide rehabilitation services for Medicaid eligible individuals under the age of twenty-one (21)	Services that are medical inpatient rehabilitation services for Medicaid eligible individuals under twenty-one (21), and general medical outpatient services which meet certification requirements of the Office of Facility, Licensure and Certification.	Limited to individuals under age twenty-one (21).

MEDICAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Laboratory and X-Ray Services. Non-Hospital	Laboratory and x-ray services provided in a facility other than a hospital outpatient department.	All laboratory and x-ray services ordered and provided by or under the direction of a physician. Includes laboratory services related to the treatment of substance abuse.	Must be ordered by physician. Certain procedures may have service limits.
Nurse Practitioners' (NP) Services	Services provided by a nurse midwife, nurse anesthetist, family or pediatric NP.	Specific services within specialty.	Certain procedures may have service limits.
Other Services Speech Therapy Physical therapy Occupational Therapy	NA	Treatment or other measures provided by speech, physical or occupational therapists to correct or ameliorate any condition within the scope of their practice.	Hearing aid evaluations, hearing aids, hearing aid supplies, batteries and repairs are limited to enrollees under age twenty-one (21) Certain procedures may have service limits or require prior authorization. Augmentation communication devices limited to children under twenty-one (21) years of age and require prior approval.
Physician Services	Services of a physician to an enrollee on an inpatient or outpatient basis.	Services are provided within the scope of medical practice of an MD or D.O. Includes medical or surgical services of a dentist, medical services related to the treatment of substance abuse, and fluoride varnish services. Physician services may be delivered using telehealth.	Certain procedures may have service limits or require prior authorization. Fluoride varnish services may only be provided to children ages six (6) months to three (3) years.
Podiatry Services	Foot care services.	Treatment for acute conditions, i.e. infections, inflammations, ulcers, bursitis, etc. Surgeries for bunions, ingrown toenails. Reduction of fractures, dislocation, and treatment of sprains. Orthotics.	Treatment of children limited to acute conditions. Routine foot care treatment for flat foot, and subluxations of the foot are not covered.
Private Duty Nursing	Nursing services for enrollees who require more individual and continuous care than is available from a visiting nurse or routinely provided by hospitals or skilled nursing facilities.	Twenty-four (24) hour nursing care if medically necessary.	Prior approval may be required. Limited to children under twenty-one (21) years of age.

MEDICAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Prosthetic Devices and Durable Medical Equipment	Devices and medical equipment prescribed by a physician to ameliorate disease, illness, or injury.	Medically necessary supplies, orthotics, prosthetics and durable medical equipment.	Certain orthotics, prosthetics, and durable medical equipment require prior approval. Certain procedures have service limits. Medical supplies and durable medical equipment in nursing facilities and ICF/MRs are covered in the per diem paid to these providers. Customized special equipment considered.
Pulmonary Rehabilitation	Individually tailored multidisciplinary approach to the rehabilitation of enrollees who have pulmonary disease.	One-on-one therapeutic procedures to increase strength or endurance of respiratory muscles and functions.	
Right from the Start Services	Services aimed at early access to prenatal care, lower infant mortality and improved pregnancy outcomes.	Care coordination and enhanced prenatal care services.	Pregnant women (including adolescent females) through sixty (60) day postpartum period and infants less than one (1) year of age. No prior authorizations can be required for RFTS services.
Rural Health Clinic Services: Including Federally Qualified Health Centers	Physician, physician assistant (PA), and NP providing primary care in a clinic setting.	Physician, PA, NP, nurse midwife services, supplies, and intermittent visiting nurse care in designated shortage areas.	
Tobacco Cessation	Treatment for tobacco use and dependence.	Diagnostic, therapy, counseling services, and quit line services. The children's benefit also includes the provision of anticipatory guidance and risk-reduction counseling with regard to tobacco use during routine well-child visits.	
Transportation, Emergency	Transportation to secure medical care and treatment on a scheduled or emergency basis.	Emergency ambulance and air ambulance.	Emergency transportation provided to the nearest resource. By most economical means determined by patient needs.
Vision Services	Services provided by optometrists, ophthalmologists, surgeons providing medical eye care and opticians. Professional services, lenses including frames, and other aids to vision. Vision therapy.	Children-exam, lenses, frames, and needed repairs.	Adults limited to medical treatment only. Prescription sunglasses and designer frames are excluded. First pair of eyeglasses after cataract surgery. Contact lenses for adults and children covered for certain diagnosis.

**Table 2: MCO Covered Dental Services**

DENTAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Dental Services (Adult)	Services provided by a dentist, orthodontist, or oral surgeon.	Emergency services.	Adult coverage limited to treatment of fractures of mandible and manilla, biopsy, removal of tumors, and emergency extractions. TMJ surgery and treatment not covered for adults.
Dental Services (Children)	Services provided by a dentist, orthodontist or oral surgeon or dental group to children under the age of twenty-one (21).	Emergency and non-emergency: surgical, diagnostic, preventive, and restorative treatment, periodontics, endodontics, orthodontics, prosthodontics, extractions, and complete or partial dentures.	Limited to individuals under age twenty-one (21).

**Table 3: MCO Covered Behavioral Services \***

BEHAVIORAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Behavioral Health Rehabilitation for Individuals Under Age twenty-one (21), Psychiatric Residential Treatment Facility	Behavioral health rehabilitation performed in a children’s residential treatment facility.	Diagnosis, evaluation, therapies, and other program services for individuals with mental illness, mental retardation, and substance abuse.	Procedure specific limits on frequency and units.
Behavioral Health Outpatient Services	Behavioral health clinics, behavioral health rehabilitation, targeted case management, psychologists, and psychiatrists. (Emergency room services are included in the MCO benefits package.)	Diagnosis, evaluation, therapies, including Medication Assisted Treatment, and other program services for individuals with mental illness, mental retardation, and substance abuse.	Procedure specific limits on frequency and units. Only assertive community treatment (ACT) providers certified by DHHR or the Bureau of Behavioral Health and Health Facilities may provide ACT services. Excludes children’s residential treatment.

BEHAVIORAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Psychological Services	Services provided by a licensed psychologist in the treatment of psychological conditions.	Evaluation and treatment, including individual, family, and group therapies. Psychological services may be delivered using telehealth.	Evaluation and testing procedures may have frequency restrictions.
Hospital Services, Inpatient – Behavioral Health and Substance Abuse Stays	Inpatient hospital services related to the treatment of mental disorders or substance abuse disorders.	Inpatient hospital services related to the diagnosis, evaluation, and treatment of behavioral health or substance abuse disorders.	NA
Inpatient Psychiatric Services for Individuals Under Age twenty-one (21)	Inpatient psychiatric facility services furnished at a psychiatric hospital or a distinct part psychiatric unit of an acute care or general hospital under the direction of a physician for individuals under age twenty-one (21).	Active treatment of psychiatric condition through an individual plan of care including post discharge plans for aftercare. Service is expected to improve the enrollee’s condition or prevent regression so the service will no longer be needed.	Certification must be made prior to admission that outpatient behavioral health resources available in the community did not meet the treatment needs of the enrollee. Pre-admission and continued stay prior authorization.
Drug Screening	Laboratory service to screen for presence of one or more drugs of abuse.	Screening ordered by the treating practitioner that is deemed medically necessary and reasonable within commonly accepted standards of practice. Results are intended to alter patient management decisions. Full scope of benefits detailed in WV Provider Manual, Chapter 529.	Standing orders must be individualized for each enrollee and updated every thirty (30) calendar days; drug screenings in excess of twenty-four (24) per calendar year are subject to prior authorization. All limitations are detailed in WV Medicaid Provider Manual, Chapter 529.2.
Substance Use Disorder (SUD) Services	Targeted case management and physician-supervised medication and counseling services provided to treat to those with a SUD.	Comprehensive SUD state plan and waiver services listed in Article III, Section 11.10	Opioid Treatment Program services included in the SUD waiver will be provided through Medicaid FFS.
Serious Emotional Disturbance Waiver Services	Provides children with some mental health conditions, special intensive support to help them remain in their homes and communities	To be defined, pending approval by CMS	To be defined, pending approval by CMS.

\* An outpatient follow-up session immediately following the discharge from the facility is an MCO covered benefit.

### Medicaid Benefits Covered Under FFS Medicaid

The following services are excluded from MCOs' capitation rates but will remain covered Medicaid services for persons who are enrolled in MCOs. The State will continue to reimburse the billing provider directly for these services on a FFS basis. The State may consider the use of specialized carve-outs in the future.

**Table 4: Medicaid Benefits Covered Under FFS Medicaid**

MEDICAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Abortion	Pregnancy termination determined to be Medically Necessary by the attending physician in consultation with the patient in light of physical, emotional, psychological, familial, or age factors (or a combination there of) relevant to the well-being of the patient.	Drugs or devices to prevent implantation of the fertilized ovum and for medical procedures necessary for the termination of an ectopic pregnancy.	Written physician certification of medical necessity. All Federal and State laws regarding this benefit must be adhered to.
Early Intervention Services for Children Three (3) Years and Under	Early intervention services provided to children three years and under through the Birth to Three (3) program.	Services provided by enrolled Birth to Three providers.	
ICF/MR-Intermediate Care Facility for the Mentally Retarded	Community based services for the mentally retarded and those with related conditions.	Services provided both in and out of a group living facility which include but are not limited to: physician services, nursing services, dental, vision, hearing, laboratory, dietary, recreational, social services, psychological services, habilitation, and active treatment	Services are provided based on a plan of care developed by an interdisciplinary team headed by a physician. Enrollee must be certified as needing ICF/MR level of care by physician and psychologist. Limited to the first thirty (30) calendar days.
Nursing Facility Services	Facility based nursing services to those who require twenty-four (24) hour nursing level of care.	Full range of nursing, social services and therapies.	Not covered.

MEDICAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Personal Care Services	Medically necessary activities or tasks ordered by a physician, which are implemented according to a Nursing Plan of Care developed and supervised by a registered nurse. These services enable people to meet their physical needs and be treated by their physicians as outpatients, rather than on an inpatient or institutional basis.	Services include those activities related to personal hygiene, dressing, feeding, nutrition, environmental support functions, and health-related tasks.	Room and board services, services which have not been certified by a physician on a Personal Care Medical Eligibility Assessment (PCMEA) or are not in the approved plan of medically necessary care developed by the registered nurse, hours that exceed the sixty (60) hours per member per month (PMPM) limitation that have not been prior authorized, services provided by an enrollee's spouse or parents of a minor child, and supervision that is considered normal childcare.
Personal Care for Individuals Enrolled in the Aged/Disabled Waiver	Community care program for elderly.	Assistance with activities of daily living in a community living arrangement. Grooming, hygiene, nutrition, non-technical physical assistance, and environmental.	Limited on a per unit per month basis. Physicians order and nursing plan of care is required.
Prescription Drugs	Simple or compound substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance.	Prescription drugs dispensed on an ambulatory basis by a pharmacy, family planning supplies, diabetic supplies, vitamins for children to age twenty-one (21), and prenatal vitamins.	Not Covered: Drugs for weight gain, cosmetic purposes, hair growth, fertility, less than effective drugs and experimental drugs. Hemophilia blood factors are covered by Medicaid FFS. Drugs and supplies dispensed by a physician acquired by the physician at no cost are not covered. Hemophilia-related clotting factor drugs and Hepatitis-C virus-related drugs are covered by FFS.
School-based Services	Services provided by a physical therapist, speech therapist, occupational therapist, nursing care agency, or audiologist in a school-based setting.	Services provided in a school-based setting.	Limited to individuals under age twenty-one (21). Refer to the FFS Medicaid provider manuals for an explanation of service limitations.

MEDICAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Organ Transplant Services	Transplantation of organs and tissues	Organ transplant services are covered when considered generally safe, effective, and medically necessary, and when no alternative medical treatment as recognized by the medical community is available. The transplant must be utilized for the management of disease as a recognized standard treatment in the medical community and must not be of an investigational or research nature and must be used for end-stage diseases, not as prophylactic treatment.	Corneal transplant services are covered under managed care, not FFS.
Substance Use Disorder (SUD) Services	Physician-supervised daily or several times weekly opioid agonist medication and counseling services provided to maintain multidimensional stability to those with severe opioid use disorder.	Opioid Treatment Program services (methadone only)	Must be provided in a Department-licensed methadone clinic and in accordance with ASAM® criteria.
Transportation, Non-emergency	Routine medical transportation to and from Medicaid covered scheduled medical appointments.	Includes transportation via multi-passenger van services and common carriers such as public railways, buses, cabs, airlines, and private vehicle transportation by individuals. Ambulance services as appropriate	Prior authorization by BMS is required for multi-passenger van services. Prior authorization by county DHHR staff is required for transportation by common carriers.

### Abortion Services

Under the terms of this Contract, MCO may not reimburse Medicaid providers for the services provided enrollees under any reported and verified abortion CPT codes. Abortion Services will be reimbursed under FFS Medicaid.

**Table 5: Additional HCBS Covered by the MCO Under the SED Waiver**

SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Assistive Equipment	An item, piece of equipment or product system that is used to address a member's needs that arise as a result of his/her serious emotional disturbance (SED).	The equipment should increase, maintain or improve functional capabilities of the member, assist him/her to avoid an out-of-home placement. This category can also include the evaluation of assistive equipment needs of a member, as well as costs of acquisition training.	Up to \$500.00 Per Service Year Plan.  In combination with Specialized Therapy.
Case Management	Services to assist members in gaining access to needed waiver and other state plan services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is granted.	The Case Manager is responsible for engaging the member and parent/caregiver in a partnership of shared decision-making and service plan development and implementation throughout their enrollment in the CSEDW. The Case Manager ensures and coordinates a comprehensive set of supports, resources, and strategies for the member and parent/caregiver. S/he works closely with providers to assure that waiver services and treatment modalities augment each other for optimal outcomes for members and families.	Up to 874 units per service year.  Caseloads capped at 20 members per case manager.
Community Transition (Ages 18-21)	Non-recurring set-up services/expenses for individuals ages 18-21 who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses.	Allowable expenses are those necessary to enable a person to establish a basic household but do not cover room and board.	Up to \$3,000 for a one-time transition period.

SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Mobile Response	24-hour services designed to respond immediately to issues that threaten the stability of the member's placement and his/her ability to function in the community as determined by the family.	This service is intended to be of very short duration and primarily to link to other services and resources. This service may only be delivered in an individual, one-to-one session. This service includes: de-escalation, issue resolution support, and the development of a stabilization plan for any additional services that are needed to resolve the immediate situation.	Up to 14 hours per week.
Day Habilitation: Independent Living/Skills Building (Ages 15-21)	Services to facilitate the member's community inclusion and remaining in his/her home. Services include therapeutic recreation, job development, and independent living/skills building, and are provided in local community settings (such as libraries, stores, parks, city pools, etc.).	Independent living/skills building can be related to activities of daily living, such as personal hygiene, household chores, and socialization, if these skills are affected by the member's SED. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, community inclusion, relationship building, employment skills, self-advocacy and informed choice necessary to successfully function in the home and community.	Up to 40 hours per week.  In combination with Supported Employment and Job Development.

SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Supported Employment (Ages 18-21)	Ongoing support services for members ages 18-21 who, because of their SED, need intensive support to obtain and maintain employment in an integrated, competitive work setting, compensated at or above the state's minimum wage, at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without SED. Services may include negotiation with prospective employers, job coaching, transportation, and other workplace supports that enable the member to be successful in integrating into the job setting.	Services may include negotiation with prospective employers, job coaching, transportation, and other workplace supports that enable the member to be successful in integrating into the job setting.	Up to 40 hours per week.  In combination with Independent Living/Skills Building and Job Development.
In-Home Family Therapy	Counseling and training services for the member and family provided by a licensed mental health professional.	This service includes individual and family therapy in the family home and should assist the family in the acquisition of knowledge and skills necessary to understand and address the specific needs of the member in relation to his/her mental illness and treatment, such as development and enhancement of the family's problem-solving skills, coping mechanisms, and strategies for the member's symptom/behavior management.	Up to 2 sessions per day in combination with both codes.

SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
In-Home Family Support	Services to allow the member and family to practice and implement the coping strategies introduced by the in-home therapist.	The family support worker works with the member and family on the practical application of skills and interventions that will allow the member and family to function more effectively. The family support worker assists the family therapist by helping the parent/child communicate their concerns; providing feedback to the therapist about observable family dynamics; helping the family and youth implement changes discussed in family therapy and/or parenting classes; supporting, and encouraging new parenting techniques; helping parents learn new parenting skills specific to meet the needs of their child; participating in family activities and supports parents in applying specific and on-the-spot parenting methods in order to change family dynamics.	Up to 2 hours per day.

SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Prevocational Services: Job Development (Ages 15-21)	Provides learning and work experiences, including volunteer work and personal care activities, where the individual can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings.	Job Development should enable each member to attain the highest level of work in the most integrated setting and with the job matched to the member's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines. Services are intended to develop and teach general skills that lead to competitive and integrated employment including, but not limited to: ability to communicate effectively with supervisors, co-workers and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; general workplace safety and mobility training.	Up to 40 hours per week.  In combination with Independent Living/Skills Building and Supported Employment.
Non-Medical Transportation	Services offered to enable members with SED to be transported to and from local, public community locations for services specified by the individual's service plan.	This service is offered in addition to Medicaid medical transportation required under 42 CFR 431.53 and transportation services under the Medicaid state plan, defined at 42 CFR 440.170(a) (if applicable), and does not replace them. Transportation services under the SED waiver are offered in accordance with the individual's service plan.	Up to 9,600 miles per year.

SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Respite Care (In and Out-of-Home)	Services provided to temporary relieve' the member's regular caregiver and include all the necessary care that the usual caregiver would provide during that period.	In-Home Respite must be provided i' the member's home, which is defined as a natural family home or a certified therapeutic foster care home. Out-of-Home Respite must be provided by a certified therapeutic foster care home. Both types of respite may be provided in the local public community.	Up to 2,304 units per year combined with in/out-of-home.
Peer Parent Support	Services are designed to offer support to the parent/guardian of the member with SED. The services are geared toward promoting parent/guardian empowerment, enhancing community living skills, and developing natural supports.	This service connects the parent/caregiver with a parent(s) who are raising or have raised a child with mental health issues and are personally familiar with the associated challenges.	Up to 2 hours per week.
Specialized Therapy	Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of a member's needs that arise as a result of his/her SED.	The service is intended to assist the member in acquiring the knowledge and skills necessary to understand and address these treatment needs, e.g., developing and enhancing problem-solving skills, coping mechanisms, strategies for the member's symptom/behavior management.	Up to \$500.00 Per Service Year Plan.  In combination with Assistive Technology.

**Table 6: Covered SNS Delivered Through the ASO**

SNS Services CATEGORY	SNS	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
CPS Family Support Services				
CPS Family Preservation Services				
CPS Foster Care Services				
Chafee Foster Care Independence Program				
CPS Reunification Services				
CPS Adoption Preservation Services				
Youth Services Family Preservation Services				
Youth Services Foster Care Services				
Youth Services Chafee Foster Care Independence Program				
Youth Services Reunification Services				

Refer to BCF utilization management manual available on the DHHR website for an explanation of the scope of benefits and service limitations.

**APPENDIX B: OVERVIEW OF WEST VIRGINIA'S SFY 2020 PAYMENT  
METHODOLOGY AND CAPITATION RATES FOR SPECIALIZED MANAGED  
CARE PLAN FOR CHILDREN AND YOUTH**

**(under a separate cover)**

## **APPENDIX C: MARKETING POLICIES**

Applicable Legal Authorities:

42 U.S.C. §1396u-2

42 CFR §438.104

The MCO is required to comply with the Marketing Policies as they relate to Medicaid or BCF programs. All Marketing Policies are applicable to the MCO, its agents, Subcontractors, and providers. The Marketing Policies, Appendix C may be amended by the Department at any time and changes will be distributed to the MCO.

Violation of any of the Marketing Policies is subject to remedies, as outlined in this Contract.

### **C-1 Marketing Standards**

The MCO may conduct general advertising that does not specifically solicit the Medicaid population. Enrollment will be handled by the Department through a Contract with a central enrollment broker.

The MCO must submit to the Department for prior written approval a marketing plan and all marketing materials prepared pursuant to said plan and this Contract. The MCO must distribute the marketing materials to its entire service area. General enrollee health education brochures and enrollee health education materials do not require approval from the Department. The Department will review the marketing plan and all marketing materials as soon as possible but within forty-five (45) calendar days to ensure compliance with this Contract. The MCO agrees to engage only in marketing activities that are pre-approved in writing by the Department.

### **C-2 Approved Marketing Practices**

The list of approved Marketing practices is not intended to be exhaustive. The following list is applicable to the MCO, its agents, Subcontractors, and MCO providers:

1. The MCO is allowed to send outreach materials and non-Marketing correspondence to its enrollees. The content of such mailings must be approved by the Department prior to distribution;
2. The MCO may send plan specific materials to potential enrollees at the potential enrollee's request. The content of such mailings must be approved by the Department prior to distribution;
3. The MCO may only provide plan specific information during incoming calls from potential enrollees. The MCO may return telephone calls to potential enrollees only when

requested to do so by the caller. The content of such call scripts must be approved by the Department prior to distribution;

4. The MCO may respond to direct questions from potential enrollees with accurate information during such telephone calls;
5. The MCO may survey their former and current enrollees;
6. The MCO may provide Gifts approved by the Department to encourage current enrollees to participate in the surveys;
7. The MCO may distribute materials and information that purely educate its enrollees on the importance of completing the State's Medicaid eligibility renewal process in a timely fashion; and
8. At the Departments' approval, the MCO may provide information about a Qualified Health Plan (QHP) to potential enrollees who could enroll in such a plan as an alternative to the Medicaid managed care plan due to a loss of Medicaid eligibility or to potential enrollees who may consider the benefits of selecting an Medicaid managed care plan that has a related QHP in the event of future eligibility changes. Such information may not be included within marketing materials.

### **C-3 Prohibited Marketing Practices**

An MCO engaging in prohibited Marketing practices listed below will be in violation of this Contract and Marketing Policy. This list is not intended to be exhaustive.

The following prohibitions are applicable to the MCO, its agents, Subcontractors, and MCO providers:

1. Distributing Marketing materials without prior Department approval;
2. Using the word, "Mountain," or phrase, "Mountain Health," "Health Bridge", except when referring to Mountain Health Trust, West Virginia Health Bridge or other State programs;
3. Distributing Marketing materials written above the 6<sup>th</sup> grade reading level, unless approved by the Department;
4. Offering gifts valued over \$15 to potential enrollees;
5. Providing gifts to providers for the purpose of distributing them directly to the MCO's potential enrollees or current enrollees;
6. Directly or indirectly, engaging in door-to-door, email, text, telephone, and other Cold Call Marketing activities;
7. Marketing in or around public assistance offices, including eligibility offices;
8. Using spam (an unwanted, disruptive commercial message posted on a computer network or sent by email);

9. Making any assertion or statement (orally or in writing) that the MCO is endorsed by CMS, a federal or state government agency, or similar entity;
10. Knowingly marketing to persons currently enrolled in another MCO directly by mail, phone or electronic means of communication;
11. Inducing or accepting an enrollee's MCO enrollment or MCO disenrollment;
12. Using terms that would influence, mislead, or cause potential enrollees to contact the MCO, rather than the Enrollment Broker, for enrollment;
13. Portraying competitors in a negative manner;
14. Using absolute superlatives (e.g., "the best," "highest ranked," "rated number 1") unless they are substantiated with supporting data provided to the Department;
15. Making any written or oral statements containing material misrepresentations of fact or law relating to the MCO's plan or the Medicaid program, services, or benefits;
16. Making potential enrollee gifts conditional based on enrollment with the MCO;
17. Charging enrollees for goods or services distributed at MCO or Medicaid events;
18. Charging enrollees a fee for accessing the MCO's website;
19. Influencing enrollment in conjunction with the sale or offering of any private insurance;
20. Tying enrollment in the Medicaid MCO with purchasing (or the provision of) other types of private insurance;
21. Using marketing agents who are paid solely by commission;
22. Posting MCO-specific, non-health related materials or banners in provider offices;
23. Conducting potential enrollee orientation in common areas of providers' offices;
24. Allowing providers to solicit enrollment or disenrollment in an MCO, or distribute MCO-specific materials at a Marketing activity (This does not apply to health fairs where providers do immunizations, blood pressure checks, etc. as long as the provider is not soliciting enrollment or distributing plan specific MCO materials.);
25. Purchasing or otherwise acquiring mailing lists from third party vendors, or for paying Department's contractors or Subcontractors to send plan specific materials to potential enrollees;
26. Referencing the commercial component of the MCO in any Marketing materials;
27. Discriminating against an enrollee or potential enrollee because of race, age, color, religion, natural origin, ancestry, marital status, sexual orientation, physical or mental

disability, health status or existing need for medical care, with the following exception: certain gifts and services may be made available to enrollees with certain diagnoses;

28. Assisting with Medicaid MCO enrollment form;
29. Making false, misleading or inaccurate statements relating to services or benefits of the MCO or Medicaid program, or relating to the providers or potential providers contracting with the MCO; and
30. Direct Mail Marketing to potential enrollees.

#### **C-4 MCO Social Media Marketing Practices**

In addition to all marketing requirements outlined in this Contract, the MCO must comply with the social media Marketing practices as outlined below.

##### **D-4.1 Social Media Marketing Guidelines**

The following list is applicable to the MCO, its agents, Subcontractors, and MCO providers:

1. At the Department's approval, the MCO may partake in forms of social media advertising (i.e. Twitter, Facebook, Instagram);
2. At the Department's approval, the MCO may purchase advertisement banners on social media outlets. The content of such advertisements must be approved by the Department prior to distribution;
3. The MCO may post MCO Medicaid events on social media sources. The content of such posts must be approved by the Department approval prior to posting;
4. The MCO may post general non-advertising information regarding MCO activities. The content of such posts does not require Department's prior approval; and
5. Any enrollee complaints received through the social media sources must be processed and resolved through the general complaint intake system.

##### **C-4.2 Social Media Prohibitions**

The following prohibitions are applicable to the MCO, its agents, Subcontractors, and MCO providers:

1. Posting or sending any protected private information on social media source;
2. Advertising on social media platforms that entail direct communication with potential enrollees. This list includes, but is not limited to: Snapchat, Skype, WhatsApp, Facebook Messenger, MeetUp, Viber, and any other personal communication services;
3. Responding to any comments on social media posts from potential enrollees except when to provide general response, such as MCO phone number, links to the MCO web site or the enrollment broker phone number;

4. Partaking in individual communication on social media outlets;
5. Requesting followers or adding individuals as friends (i.e. friends on Facebook, followers on Instagram or Twitter); and
6. Tagging individuals on social media source.

### **C-5 Reporting and Investigating MCO Marketing Violations**

The MCO must establish a process to ensure fair and consistent investigation of alleged violations of the Department's Marketing Policies.

Upon written receipt of any alleged MCO violation(s) from the Department, the MCO must:

1. Acknowledge receipt, in writing, within one (1) business day from the date of the receipt of the alleged violation.
2. Begin investigation of the alleged violation and complete investigation within fourteen (14) calendar days from the date of the receipt of the alleged violation.
3. Analyze the findings of the investigation and report findings to the Department.

### **C-6 Provider Training**

The MCO is required to inform its network providers of the Marketing policies.

### **C-7 Gifts to Potential Enrollees**

MCOs may provide promotional gifts valued at or under \$15 to potential MCO enrollees. MCOs may distribute promotional gifts valued at more than \$15 to current enrollees only. A gift worth \$15 or less must be based on the retail purchase price of the gift item. The MCO may not provide gifts to providers for the purpose of distributing them potential enrollees, unless such gifts are placed in the providers' office common areas and are available to all patients.

### **C-8 MCO Enrollee Gifts**

The MCO may solicit its currently enrolled enrollees for participation in MCO health-related activities or MCO surveys.

The MCO may provide gifts valued at \$50 or less per enrollee per gift to encourage enrollee attendance or participation in MCO health-related activities or MCO surveys. Enrollee gifts may not be converted to cash.

The MCO must not exceed the total annual limit of \$250 per each enrollee for all gifts. The Department must provide prior approval of all monetary and non-monetary compensation provided to enrollees in exchange for participating in any MCO activities.

## APPENDIX D: SUMMARY OF MCO REPORTING REQUIREMENTS

All MCO reports submitted under this Contract must reflect program-related data only unless otherwise requested by the Department.

Reporting Requirement	Timeframe				Due Date
	Monthly	Quarterly	Annually	Other	
<b>Quarterly Reporting</b>					
1: Enrollment and Membership Report		X			Within forty-five (45) calendar days of end of quarter (by the 15 <sup>th</sup> day of the second month following the end of the reporting period)
2: Provider Network Status Report		X			
3: Medical Claims Processing		X			
4: Experience Summary		X			
5: Medical Grievance and Appeals Report		X			
5a: SNS Grievance and Appeals Report		X			
5b: Dental Grievance and Appeals Report		X			
5c: Behavioral Health Grievance and Appeals Report		X			
6: Lag Tables		X			
7: Summary of Claims Paid Outside Encounter Data and Sub-Capitation Arrangements		X			
7a: Experience Summary for Capitated Arrangements		X			
8: Enrollee and Provider Services		X			
9: Medicaid-Related Financial Reports (Statement of Revenue and Expenses)		X			
10: Out-of-Network Utilization Report-Physical Health		X			
10a: Out-of-Network Utilization Report-Behavioral Health		X			
<b>Quality Reporting</b>					

Reporting Requirement	Timeframe				
	Monthly	Quarterly	Annually	Other	Due Date
Written Description of PIPs and Results			X		July 15 <sup>th</sup>
PIP Progress Report		X			Within forty-five (45) calendar days of end of quarter
HEDIS			X		On or before June 15 <sup>th</sup> (audited)
QAPI Annual Evaluation Report Including Status and Results			X		On or before June 15 <sup>th</sup>
QAPI CAP				X	Within thirty (30) calendar days of identification of systemic problem
CAHPS Enrollee Survey Analysis, Action Plan and Evaluation		X	X		Annual analysis is due on or before August 15 <sup>th</sup> . Quarterly updates are due within forty-five (45) calendar days of end of quarter (see MHT-15)
Accreditation Review Report				X	Upon completion or change in status
Encounter Data	X				Within thirty (30) calendar days of end of month
Adult and Child Core Quality Measures			X		On or before September 1 <sup>st</sup>
<b>Provider Reporting</b>					
Provider Network Data	X				Electronic provider directories to be submitted to the Department monthly
Provider Network Adequacy		X	X	X	<ul style="list-style-type: none"> <li>• Full network – Annually by October 31st</li> <li>• All Network changes by specialty – Quarterly, 45 days after end of the quarter</li> <li>• PCP changes –fourteen (14) days after the change</li> <li>• Hospital changes –immediately</li> <li>• Material changes of other providers affecting service delivery- fourteen (14) days after the change</li> </ul>
Provider Satisfaction Survey		X			Within forty-five (45) calendar days of end of quarter (by the 15 <sup>th</sup> day of the second month following the end of the reporting period)

Reporting Requirement	Timeframe				
	Monthly	Quarterly	Annually	Other	Due Date
Suspension and Adverse Enrollment Action Report (formerly the CAF Suspension and PDC reports)	X				By the 15th of the following month
<b>Financial Reporting</b>					
Annual Financial Statements			X		On or before June 1 <sup>st</sup>
Offices of the Insurance Commissioner Reports – Quarterly and Annually		X	X		Concurrent with DOI submission
Third Party Liability Cases Not Pursued	X				The 15 <sup>th</sup> of each month (to include all events from the prior month)
Provider-Preventable Conditions					To Be Determined
PCP Payment Methodology				X	Upon request from DHHR
Directed Payments Report		X			The 15 <sup>th</sup> of each month (to include all events from the prior month)
Provider Payment Suspensions Report	X				
MLR Reports and Calculations			X		Eight (8) months after the end of the SFY
Recovery of All Overpayments Report (included in the FWA Report)	X				By the 15 <sup>th</sup> of the month
IMD Report	X				Submit on the 15 <sup>th</sup> and 30 <sup>th</sup> of each month
Hysterectomies and Sterilizations			X		Submit attestation by October 1 <sup>st</sup>
EPSDT Services and Reporting				X	Submit attestation by October 1 <sup>st</sup>
<b>Other State Required Reporting</b>					
Business Continuity Plan				X	Within ten (10) business days of DHHR written request
Disaster Recovery Plan				X	Within ten (10) business days of DHHR written request
Information Security Plan				X	Within ten (10) business days of DHHR written request

Reporting Requirement	Timeframe				Due Date
	Monthly	Quarterly	Annually	Other	
Children's PRTF Services Report	X				The 15 <sup>th</sup> of each month (to include all events from the prior month)
System Quality Assurance Plan				X	Within ten (10) business days of DHHR written request
Sexually Transmitted Diseases			X		Submit attestation by October 1 <sup>st</sup>
Tuberculosis			X		Submit attestation by October 1 <sup>st</sup>
Communicable Diseases			X		Submit attestation by October 1 <sup>st</sup>
MCO Annual Report			X		On or before April 1 <sup>st</sup>
Organization Chart			X		On or before October 1 <sup>st</sup>
Marketing Plan			X		On or before October 1 <sup>st</sup>
Subcontractor Monitoring Plan				X	Within ten (10) business days of BMS written request
Data Accuracy and Completeness Plan			X		On or before October 1 <sup>st</sup>
Activities Summary, Analyses and Results of Provider/Beneficiary Utilization to Detect FWA			X		On or before June 15 <sup>th</sup>
HB 4217 Report			X		On March 30 <sup>th</sup> of each year
Alternative Payment Model Report			X		August 15 <sup>th</sup>
FWA Reporting	X				By the 15 <sup>th</sup> of the following month
Disclosure of Ownership Reporting			X	X	<ul style="list-style-type: none"> <li>Annually, on or before July 1<sup>st</sup>;</li> <li>Upon request, within thirty-five (35) calendar days; or</li> <li>Upon change in ownership, within thirty-five (35) calendar days</li> </ul>
FWA Internal Compliance Plan			X		On or before October 1 <sup>st</sup>
Parity in Mental Health and Substance Use Disorder (SUD) Benefits Compliance Plan			X		On or before June 30 <sup>th</sup>
Claims Aging Report	X				By the 15 <sup>th</sup> of the following month

Reporting Requirement	Timeframe				
	Monthly	Quarterly	Annually	Other	Due Date
SNS underserved areas of the State where they additional SNS providers are needed	X				
SED Waiver Reporting, including but not limited to: authorization reporting; grievances, appeals, and denials reporting; member satisfaction reporting; staffing/training reports; service plan reporting; critical incident reporting; claims reporting.	X	X	X	X	As defined by the SED Waiver Program

# APPENDIX E 1: DATA CERTIFICATION FORM

## STATE OF WEST VIRGINIA

### DATA CERTIFICATION FOR \_\_\_\_\_ REPORT SUBMISSION

Date Of Data Submission: MM/DD/YYYY

Managed Care Program Type: \_\_\_\_\_

Data Submitted to: \_\_\_\_\_

Name of Agency Official  
\_\_\_\_\_

Agency/Division

Method Of Data Transmission: \_\_\_\_\_ Electronic \_\_\_\_\_ Hard Copy

I hereby certify that, in my belief and to the best of my knowledge (based on all information available to me), the data contained in the \_\_\_\_\_

<name of report>

Report submission by \_\_\_\_\_

<MCO>

is accurate, complete, and truthful, and that it has no known or suspected material limitations or imperfections unless described in detail in a statement provided with this submission.

I further certify that I have authority\* to sign this certification on behalf of \_\_\_\_\_

<MCO>

Certified by\*: \_\_\_\_\_

Name

\_\_\_\_\_

Title

\_\_\_\_\_

Date of Submission

^ Data certification must be submitted concurrently with the certified data (42CFR 438.606(c)).

\* Certification must be signed by the MCO's Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who has delegated authority to sign for and who reports directly to the MCO's CEO or CFO (42 CFR 438.606(a)).

## APPENDIX E 2: DATA CERTIFICATION FOR MONTHLY AND WEEKLY ENCOUNTER DATA REPORT SUBMISSION

### STATE OF WEST VIRGINIA

Date Of Data Submission: MM/DD/YYYY

Managed Care Program Type: \_\_\_\_\_

Data Submitted to: \_\_\_\_\_

\_\_\_\_\_  
Name of Agency Official

\_\_\_\_\_  
Agency/Division

Method of Data Transmission:  Electronic  Hard Copy

I hereby certify that, in my belief and to the best of my knowledge (based on all information available to me at the time such data was submitted), the data contained in the MCO MedEncs YYYYMM YYYYMM.txt report submission by MCO Name was accurate, complete, and truthful, and that it had no known or suspected material limitations or imperfections unless described in detail in a statement provided with that submission.

I further certify that I have authority\* to sign this certification on behalf of MCO.

Certified by\* :

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name

\_\_\_\_\_  
Title

MM/DD/YYYY

Date

^ Data certification must be submitted concurrently with the certified data (42 CFR 438.606(c)).

\* Certification must be signed by the MCO's Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who has delegated authority to sign for and who reports directly to the MCO's CEO or CFO (42 CFR 438.606(a)).

## APPENDIX F: SERVICE LEVEL AGREEMENTS (SLA) AND LIQUIDATED DAMAGES MATRIX

All areas of responsibility and all requirements in the Contract will be subject to performance evaluation by the Department. Any and all responsibilities or requirements not fulfilled may have remedies, and the Department will assess either actual or liquidated damages. This Appendix outlines performance standards that carry liquidated damage values.

#	Program Non-Performance	Measurement Period	Liquidated Damages
1	Failure to submit required reports, information requests, documentation, ad hoc reports, data certification forms, overpayment remittances, or any other item required within the timeframes provided by this Contract or by the Department. The MCO may have a one (1) business day grace period following the due date of the data, report, remittance, or form. Article II, Section 4.13, unless otherwise specified in this Appendix.	Ongoing	\$250 per business day per each item that is overdue until the satisfactory submission of the required report, documentation, ad hoc report, data certification form, or data required to meet any State or federal reporting requirements After three (3) instances of non-performance during the Contract period, the amount is increased to \$1,250 per business day per each item that is overdue.
2	Failure to comply with encounter data submission requirements including the failure to address or resolve problems with encounter records in a timely manner as required by Article III, Section 5.10.	Monthly	\$1,000 per single encounter file per reporting period.
3	Failure to meet a ninety-five percent (95%) encounter acceptance rate as required by Article III, Section 5.10	Monthly	\$100 per each rejected encounter below the ninety-five percent (95%) acceptance rate threshold.
4	Failure to resolve at least ninety-eight percent (98%) of enrollee appeals within thirty (30) calendar days from the date the appeal is filed with the MCO, unless an enrollee requests an extension or the MCO shows that a delay is necessary and in the interest of the enrollee. Article III, Section 4.8.	Quarterly	\$1,000 for each percentage point below ninety-eight percent (98%) if the MCO fails to meet the standard.
5	Failure to notify affected enrollees of program or service site changes, at least fourteen (14) calendar days before the intended effective date of the change. Article III, Section 4.4.	Ongoing	\$250 per each incident per affected enrollee.

#	Program Non-Performance	Measurement Period	Liquidated Damages
6	Failure to report timely to DHHR significant network changes as described in Article III, Section 3.1, Network Changes.	Ongoing	\$500 per incident of non-compliance.
7	Failure to meet provider credentialing requirements, including background screening requirements, specified in Article III, Section 3.1, Provider Qualification and Selection.	Ongoing	\$500 per incident of non-compliance.
8	Failure to comply with the marketing requirements, or engagement in prohibited marketing practices. Failure to meet all social media marketing requirements, or engagement in any prohibited social media practices. Article III, Section 4.1 and Appendix C.	Ongoing	\$1,000 per each incident of non-compliance.
9	Failure to pay clean claims within thirty (30) calendar days as required in Article III, Section 237.	Monthly	Up to \$10,000 per month for any month in which the MCO fails to meet clean claims timely processing requirements.
10	Failure to pay eighteen percent (18%) annual interest on the same date as an in-network or out-of-network provider clean claim that remained unpaid beyond the thirty (30) calendar day claims payment deadline. Article III, Section 3.7, Timely Payment Requirement.	Quarterly	\$500 per each in-network clean claim for which the interest remained unpaid on the same date as a claim's payment.
11	Failure to provide timely MCO covered services as described in Appendix A of this Contract when, in the determination of DHHR, such failure results in actual harm to an enrollee or places an enrollee at risk of imminent harm.	Ongoing	\$7,500 per business day for each incident of non-compliance.
12	Failure to make at least ninety-five percent (95%) of authorization decisions and provide written notice within seven (7) calendar days of receiving the request for service for the purposes of standard authorization decisions as described in Article III, Section 6.4.	Quarterly	\$250,000 for each quarter in which the threshold is not met
13	Failure to administer enrollee copayments, including charging excess copayments for covered services, as determined by the Department and outlined in Article III, Section 4.9.	Ongoing	\$100 per each copay incident imposed in error.

#	Program Non-Performance	Measurement Period	Liquidated Damages
14	Failure to hold or improperly release funds subject to a credible allegation of fraud payment hold.	Ongoing	Amount held or released improperly.
15	Failure to adhere to the prohibitions and requirements related to program integrity activities and the recovery of overpayments as outlined in Article III, 9.	Ongoing	\$5,000 per occurrence, plus forfeiture of all related recovered overpayments.
16	In addition to the liquidated damages described in this table, the state agency reserves the right to assess a general liquidated damage with any notice of deficiency.	Ongoing	\$500 per occurrence of any deficiency.
17	Failure by the MCO to ensure at least eighty- three percent (83%) of provider calls are answered live within thirty (30) seconds during operating hours	Monthly	\$5,000 per month for non-compliance
16	Failure by the MCO to ensure the provider call abandonment rate does not exceed five percent (5%)	Monthly	\$5,000 per month for non-compliance
18	Failure by the MCO to ensure a mental health screening has been completed for any child entering the child welfare system that is not actively receiving mental health services	Monthly	\$5,000 per incident

## **APPENDIX G: MEDICAL LOSS RATIO (MLR) REPORTING METHODOLOGY**

Appendix G of this Contract outlines the requirements for the MLR reporting and for calculating any program rebate amount that may be due to the Department in the event the MCO does not meet the minimum eighty percent (85%) MLR standard as provided by Article III, Section 8.3 of this Contract. In addition to reviewing this Appendix, MCOs are advised to review the following CFR provisions prior to completing the MLR report: 42 CFR §438.8; 42 CFR 438.604; and 42 CFR §438.606.

### **General Standards for Reporting**

The MCO must demonstrate its ongoing Contract compliance with the MLR standards, as set by Article III, Section 8.3 of this Contract. The MCO must complete and submit the MLR Financial Reports to the Department, using the following schedule:

1. As required by the Department during the rate-setting and supplemental data request process;
2. Annually, eight (8) months following the end of the State Fiscal Year (SFY) for CMS submission; and
3. Following any instance where BMS makes a retroactive change to the capitation payments for a MLR reporting year in which the MLR report has already been submitted to BMS, the MCO must re-calculate the MLR for each MLR reporting year affected by the change and resubmit the reports to BMS per 42 CFR §438.

The MCO must require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the MCO within one hundred and eighty (180) calendar days of the end of the MLR reporting year or within thirty (30) calendar days of being requested by the MCO, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting per 42 CFR 438.8(k)(3). The MCO must maintain and make available to the Department upon request any data used to calculate MLRs and MLR rebates under this Appendix together with all supporting information required to determine the methods for calculations outlined in this Appendix.

### **Certification of Accuracy**

42 CFR §438.606 and 42 CFR § 438.8(n) require that the MLR report submission be certified that based on best information, knowledge, and belief, the data, documentation, and information provided in the report is accurate, complete, and truthful. The certification must be signed by the MCO's Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who reports directly to the CEO or CFO with delegated authority to sign for the CEO or CFO so that the CEO or CFO is ultimately responsible for the certification. MLR report submissions without the required certification will not be accepted.

### **Calculating MLRs**

The MCO must calculate its program MLR utilizing the following formula:

The MLR is the ratio of the numerator (as defined in accordance with 42 CFR 438.8(e)) to the denominator (as defined in accordance with 42 CFR §438.8(f)). The MLR must be rounded to three decimal places. For example, if an MLR is 0.7988, it must be rounded to 0.799 or 79.9 percent. If an MLR is 0.8253 or 82.53 percent, it must be rounded to 0.825 or 82.5 percent.

The MCO may add a credibility adjustment to a calculated MLR if the MLR reporting year experience is partially credible. The credibility adjustment is added to the reported MLR calculation before calculating any rebates and in accordance with 42 CFR §438.8(h).

If the MCO's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards.

MCOs, PIHPs, or PAHPs will aggregate data for all Medicaid eligibility groups covered under the contract with the State.

### **Allocation of Expenses**

The MCO must follow a generally accepted accounting methodology anticipated to yield the most accurate results and must ensure the following:

1. Any expense may be reported under only one type of expense, unless a portion of the expense fits under the criteria for one type of expense and the remainder fits the criteria for another type of expense. In this case, the expense must be pro-rated between the types of expenses.
2. Expenses that benefit multiple contracts or multiple populations within this contract must be reported on a pro rata basis.
3. Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense.
4. Any expenses that relate solely to the operation of a reporting entity (e.g. personnel costs for processing claims) must borne only by the reporting entity and may not be attributed to other entities.
5. Liquidated damages, provider overpayment remittance to the State and interest assessments, if any, are unallowable costs and are neither medical expenses nor premium payments.

### **Incurred Medical Expenses (Numerator)**

The numerator of an MLR must include total incurred medical expenses defined.

Per 42 CFR §438.8(e)(2) incurred claim means the following:

- Direct claims that the MCO paid to providers (including under capitated contracts with network providers) for services or supplies covered under the contract and services meeting the requirements of additional and Value-Added services per 42 CFR §438.3(e) provided to MCO enrollees;
- Unpaid claims liabilities for the MLR reporting period, including claims reported that are in the process of being adjusted or claims incurred but not reported;
- Withholds from payments made to network providers;

- Claims that are recoverable for anticipated coordination of benefits;
- Claims payments recoveries received as a result of subrogation;
- Incurred but not reported claims based on past experience, and modified to reflect current conditions, such as changes in exposure or claim frequency or severity;
- Changes in other claim-related reserves;
- Reserves for contingent benefits and the medical claim portion of lawsuits;
- The amount of incentive and bonus payments made, or expected to be made, to network providers;
- The amount of claims payments recovered through fraud reduction efforts, not to exceed the amount of fraud reduction expenses. The amount of fraud reduction expenses must not include fraud prevention activities. MCO calculation and reporting of the fraud prevention activities as adopted for the private market at 45 CFR §158 is currently suspended for implementation by CMS;
- Amounts that must either be included in or deducted from incurred claims include, respectively, net payments or receipts related to State mandated solvency funds; and
- Additional elements are required by the Department.

Incurred medical claims and expenses may not include:

- Overpayment recoveries received from network providers;
- MCO prescription drug rebates received and accrued, if any;
- Amounts paid to third party vendors for secondary network savings;
- Amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management;
- Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for State plan services or services meeting the definition in 42 CFR §438.3(e) and provided to MCO enrollees;
- Fines and penalties assessed by regulatory authorities;
- Amounts paid to the Department as MLR remittance;
- Amounts paid to network providers as pass-through payments; and
- Additional elements are required by the Department.

### **Activities that Improve Health Care Quality (Numerator)**

The MCO must account for expenditures for activities that improve health care quality, as described in this Appendix.

Activities conducted by the MCO to improve quality must meet the following requirements:

- (1) MCO activity related to any EQR-related activity as described in 42 CFR §438.358(b) and (c); or
- (2) The activity must be designed to:
  - a. Improve health quality.
  - b. Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements.
  - c. Be directed toward individual enrollees or incurred for the benefit of specified segments of enrollees or provide health improvements to the population beyond those

enrolled in coverage as long as no additional costs are incurred due to the non-enrollees.

- d. Be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations.

(3) The activity must be primarily designed to:

- a. Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among MCO specified populations. Examples include the direct interaction of the MCO (including those services delegated by Contract for which the MCO retains ultimate responsibility under this Contract), providers and the enrollee or the enrollee's representative (for example, face-to-face, telephonic, web-based interactions or other means of communication) to improve health outcomes, including activities such as:
  - i. Effective case management, care coordination, chronic disease management, and medication and care compliance initiatives including through the use of the medical homes model as defined in section 3502 of the ACA.
  - ii. Identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence-based medicine.
  - iii. Quality reporting and documentation of care in non-electronic format.
  - iv. Health information technology to support these activities.
  - v. Accreditation fees directly related to quality of care activities.
- b. Prevent hospital readmissions through a comprehensive program for hospital discharge. Examples include:
  - i. Comprehensive discharge planning (for example, arranging and managing transitions from one setting to another, such as hospital discharge to home or to a rehabilitation center) in order to help assure appropriate care that will, in all likelihood, avoid readmission to the hospital;
  - ii. Patient-centered education and counseling.
  - iii. Personalized post-discharge reinforcement and counseling by an appropriate health care professional.
  - iv. Any quality reporting and related documentation in non-electronic form for activities to prevent hospital readmission.
  - v. Health information technology to support these activities.
- c. Improve patient safety, reduce medical errors, and lower infection and mortality rates. Examples of activities primarily designed to improve patient safety, reduce medical errors, and lower infection and mortality rates include:
  - i. The appropriate identification and use of best clinical practices to avoid harm.
  - ii. Activities to identify and encourage evidence-based medicine in addressing independently identified and documented clinical errors or safety concerns.
  - iii. Activities to lower the risk of facility-acquired infections.
  - iv. Any quality reporting and related documentation in non-electronic form for activities that improve patient safety and reduce medical errors.
  - v. Health information technology to support these activities.

- d. Implement, promote, and increase wellness and health activities. Examples of activities primarily designed to implement, promote, and increase wellness and health activities, include:
  - i. Wellness assessments;
  - ii. Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements;
  - iii. Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition;
  - iv. Public health education campaigns that are performed in conjunction with State or local health departments;
  - v. Actual gifts or incentives that are not already reflected in claims;
  - vi. Any quality reporting and related documentation in non-electronic form for wellness and health promotion activities;
  - vii. Coaching or education programs and health promotion activities designed to change enrollee behavior and conditions (for example, smoking or obesity); and
  - viii. Health information technology to support these activities.
  
- e. Enhance the use of health care data to improve quality, transparency, and outcomes and support meaningful use of health information technology. Expenditures and activities that must not be included in quality improving activities are:
  - i. Those that are designed primarily to control or contain costs;
  - ii. Those which otherwise meet the definitions for quality improvement activities, but which were paid for with other funding separate from capitation revenue;
  - iii. Those activities that can be billed or allocated by a provider for care delivery and which are, therefore, reimbursed as clinical services;
  - iv. Establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims, including maintenance of ICD-10 code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended.
  - v. That portion of the activities of health care professional hotlines that does not meet the definition of activities that improve health quality;
  - vi. All retrospective and concurrent utilization review;
  - vii. The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network, including fees paid to a vendor for the same reason;
  - viii. Provider credentialing;
  - ix. Marketing expenses;
  - x. That portion of prospective utilization that does not meet the definition of activities that improve health quality; and
  - xi. Any function or activity not expressly included in this Appendix, unless otherwise approved by and within the discretion of the Department, upon adequate showing by the MCO that the activity's costs support the definitions

and purposes in this part or otherwise support monitoring, measuring or reporting health care quality improvement.

### **Expenditures Related to Health Information Technology (HIT) and Meaningful Use Requirements (Numerator)**

The MCO may include activities that improve health care quality such Health Information Technology (HIT) as expenses that are required to accomplish the activities allowed in this Contract and that are designed for use by MCO, its providers, or enrollees for the electronic creation, maintenance, access, or exchange of health information, as well as those consistent with Medicaid meaningful use requirements, and which may in whole or in part improve quality of care, or provide the technological infrastructure to enhance current quality improvement or make new quality improvement initiatives possible by doing one or more of the following:

1. Making incentive payments to providers for the adoption of certified electronic health record technologies and their “meaningful use” as defined by the United States Department of Health and Human Services (HHS), to the extent such payments are not included in reimbursement for clinical services as defined by this Appendix;
2. Implementing systems to track and verify the adoption and meaningful use of certified electronic health records technologies by health care providers, including those not eligible for Medicaid incentive payments;
3. Providing technical assistance to support adoption and meaningful use of certified electronic health records technologies;
4. Monitoring, measuring, or reporting clinical effectiveness including reporting and analysis of costs related to maintaining accreditation by nationally recognized accrediting organizations such as NCQA or URAC, or costs for public reporting of quality of care, including costs specifically required to make accurate determinations of defined measures (for example, CAHPS surveys or chart review of HEDIS measures) and costs for public reporting mandated or encouraged by law.
5. Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes.
6. Advancing the ability of enrollees, providers, issuers or other systems to communicate patient centered clinical or medical information rapidly, accurately and efficiently to determine patient status, avoid harmful drug interactions or direct appropriate care, which may include electronic health records accessible by enrollees and appropriate providers to monitor and document an individual patient's medical history and to support care management.
7. Reformatting, transmitting or reporting data to national or international government-based health organizations for the purposes of identifying or treating specific conditions or controlling the spread of disease.
8. Provision of electronic health records, patient portals, and tools to facilitate patient self-management.

## Denominator

The MCO denominator for an MLR reporting year must equal the adjusted premium revenue. The adjusted premium revenue is the MCO's premium revenue minus the MCO's Federal, State, and local taxes and licensing and regulatory fees; aggregated in accordance with each program reported.

**Premium revenue** must include at least the following:

- State capitation payments, excluding pass-through payments made under 42 CFR §438.6(d);
- State-developed one-time payments, for specific life events of enrollees (e.g., kick payments);
- Withhold arrangement payments to the MCO approved under 42 CFR §438.6(b)(3);
- Unpaid cost-sharing amounts that the MCO could have collected from the members under the contract, except those amounts the MCO can show it made a reasonable, but unsuccessful, effort to collect;
- All changes to unearned premium reserves;
- Net payments or receipts related to risk sharing mechanisms developed in accordance with 42 CFR §438.5 or 42 CFR §438.6.

**Federal, State, and local taxes and licensing and regulatory fees** must include at least the following:

- Statutory assessments to defray the operating expenses of any State or Federal department;
- Examination fees in lieu of premium taxes as specified by State law;
- Federal taxes and assessments allocated to MCOs, excluding Federal income taxes on investment income and capital gains and Federal employment taxes;
- State and local taxes and assessments including:
  - Any industry-wide (or subset) assessments (other than surcharges on specific claims) paid to the State or locality directly.
  - Guaranty fund assessments.
  - Assessments of State or locality industrial boards or other boards for operating expenses or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by States.
  - State or locality income, excise, and business taxes other than premium taxes and State employment and similar taxes and assessments.
  - State or locality premium taxes plus State or locality taxes based on reserves, if in lieu of premium taxes;
- Payments made by an MCO that are otherwise exempt from Federal income taxes, for community benefit expenditures as defined in 45 CFR 158.162(c), limited to the highest of either:
  - Three percent (3%) of earned premium; or
  - The highest premium tax rate in the State for which the report is being submitted, multiplied by the MCO's earned premium in the State.

## **Rebating Capitation Payments: 85% MLR Standard is Not Met**

For each MLR reporting year, the MCO must provide a rebate to the Department if the MCO does not meet the eighty-five percent (85%) MLR standard requirement. The MCO is not subject to MLR rebating during the initial contract term, March 1, 2020 to June 30, 2020, but is required to provide MLR reporting to the State for review.

In accordance with Article III, Section 8.3, an MLR percentage of less than eighty-five percent (85%) must be one hundred percent (100%) reimbursable to the State.

The MCO rebate amounts will be assessed by the Department using the MLR calculations provided within the SFY MLR Report submitted to the Department by the MCO. The MLR rebate, if any, is due to the Department in full sixty (60) calendar days after the Department notifies the MCO in writing of any MLR rebate amount due.

If MCO determines that payment of the MLR rebate by MCO will cause the MCO's risk-based capital to fall below levels required by the West Virginia Offices of the Insurance Commissioner, the MCO's responsible official must notify the Department in writing as soon as administratively possible and prior to making any MLR rebate payments to the Department.

**APPENDIX H: ALTERNATIVE PAYMENT MODEL (APM) REPORTING TEMPLATE**

<b>NAME OF MCO</b>
<b>CONTACT INFORMATION</b>
<b>INITIATIVE(S) SELECTED</b>
(Options include, but are not limited to: primary care incentives; payment for performance; shared savings arrangements; risk sharing arrangements; episodes of care/ bundled payments; and capitation payments with performance and quality requirements)
<b>DESCRIPTION OF INITIATIVE(S)</b>
(Please include provider partners, percentage of provider contracts, size and scope of initiative, effect on quality and cost to date)
*APMs excluding maternity kick provider payments.
<b>RATIONALE FOR INITIATIVE(S)</b>
<p>Which value based health care goals are supported by this initiative? Check Box(es)</p> <p><input type="checkbox"/> Improve Quality of Care</p> <p><input type="checkbox"/> Lower Costs</p> <p><input type="checkbox"/> Improve Population Health</p> <p>Further Explanation:</p>

**PERFORMANCE MEASURES**

(Each goal should be linked to one or more performance measures)

<b>Measure</b>	<b>Goal Linked</b>	<b>Source</b>

**DESCRIPTION OF MONITORING ACTIVITIES**

**EVALUATION OF EFFECTIVENESS OF PREVIOUS CONTRACT YEAR**

(Please provide performance reports)

**SUMMARY**

(Please describe lessons learned and any implemented changes)

**BARRIERS**

(Please describe any significant barriers faced and strategies developed to overcome these barriers)

**PLANS FOR NEXT CONTRACT YEAR**

## APPENDIX I: SOCIALLY NECESSARY CRIMES AND WAIVERS PROTOCOL

Effective March 1, 2010

1. Employees who work for Providers of Socially Necessary Services must possess no child or adult maltreatment substantiations and must have no criminal convictions in order to be eligible for employment unless a waiver is granted. Waivers may be requested when any of the following conditions apply:
  - a. Any convictions of crimes of deceit or dishonestly are at least ten (10) years old (i.e., forgery, bad checks);
  - b. DUI convictions must be at least five (5) years old;
  - c. Any convictions involving reckless, erratic and/or dangerous driving behaviors must be at least two years old;
  - d. Any misdemeanor drug convictions must be at least ten (10) years old;
  - e. An applicant must not be approved, employed, nor utilized if convicted of two (2) or more misdemeanors unless the convictions are far enough in the past to indicate that behavior change has occurred and a waiver is requested and approved (1-5 years, depending on the nature of the crimes);
  
2. Any convictions that are not eligible for waiver under the Department's current CIB policy will not be considered for waiver under the SNS policy. Those crimes are as follows:
  - a. Abduction;
  - b. Any violent felony crime including but not limited to rape, sexual assault, homicide, malicious wounding, unlawful wounding, felonious domestic assault or battery;
  - c. Child/adult abuse or neglect;
  - d. Crimes which involve the exploitation of a child or an incapacitated adult;
  - e. Misdemeanor domestic battery or domestic assault;
  - f. Felony arson;
  - g. Felony or misdemeanor crime against a child or incapacitated adult which causes harm;
  - h. Felony drug related offenses within the last ten (10) years;
  - i. Felony DUI within the last ten (10) years;
  - j. Hate crimes;
  - k. Kidnapping;
  - l. Murder/homicide;
  - m. Neglect or abuse by a caregiver;
  - n. Pornography crimes involving children or incapacitated adults including but not limited to, use of minors in filming sexually explicit conduct, distribution and exhibition of material depicting minors in sexually explicit conduct or sending, distributing, exhibiting, possessing, displaying or transporting material by a parent, guardian or custodian, depicting a child engaged in sexually explicit conduct;
  - o. Purchase or sale of a child;
  - p. Sexual offenses including but not limited to incest, sexual abuse, or indecent exposure;
  
3. There is no forgiveness for CPS/APS maltreatment substantiations.

Waiver Requests-Providers wishing to employ any individual with a conviction listed in section 1 should direct the following documents to the Bureau for Children and Families, 350 Capitol Street, Room 692, Charleston, WV 25301:

- Criminal Record Statement Form completed by the prospective employee prior to fingerprints being sent to the State Police. This allows the prospective employee to explain the surrounding circumstances for any criminal activity that may appear on the CIB check;
- CIB results from the West Virginia State Police; and
- A statement of why the waiver should be granted that is completed by the prospective employee. If the request is being submitted by an agency, the director of the agency must submit a statement along with the waiver request indicating support. The request will not be considered if the agency does not submit a statement of support.

## APPENDIX J: STAKEHOLDER FOCUS GROUP QUESTIONS TEMPLATE

1. Is your current agency/family committed to providing health and educational materials that appeal to various social, cultural and special needs groups?
2. Are intake forms or materials available in different languages?
3. Does your provider offer assistance for those with disabilities? For example: large print, sign language, assistive technology.
4. Does the agency have trained interpreters readily available for various languages, including sign language?
5. Do the agency/families have established connections with various communities, cultural, ethnic and religious groups to help better serve diverse groups?
6. In the past six (6) months has this agency sponsored at least one activity that has helped improve communication and teamwork between residents of different cultural, language and ethnic groups?
7. Do you have the opportunity to attend racial group holidays or functions within diverse communities? What was it?
8. Are you provided linkages with advocates for diverse communities who can give you reliable information regarding community opinions about diverse and important issues?
9. Do you have access to religious services in which you affiliate?
10. Does your care provider (Family) alter your programming or care based on your values or culture?
11. Do you feel your services are tailored to your needs?
12. Are visitations arranged in situations you and your family are comfortable- physically and emotionally?
13. Are you allowed visits with siblings, extended family, kin or your friends you want to keep in touch with from home?
14. Are you able to contact family and friends besides visitation, phone calls and letters? Do you have access to e-mail, skype, face time, texting, twitter, Facebook, Instagram, snapchat?
15. If you are celebrating a special occasion or holiday do you have input in the planning? Are your family traditions considered, foods your family likes, ways to decorate?
16. Do you have access to personal care items or services that match your needs? (such as Haircuts)
17. Do you feel you get to express your personal style in clothing and appearance?

18. Do caregivers understand or demonstrate an understanding of sex/gender issues? Are staff comfortable talking about LGBTQ issues? Does staff initiate discussions related to LGBTQ issues?
19. Do you feel that caregivers' uses inclusive language rather than identifying activities based on stereotyped gender roles?
20. Do you feel isolated or separated/segregated due to your sexual orientation? Have you been punished or given consequences for age appropriate sexual conduct that is different than what heterosexual youth would receive?
21. Did caregivers ask what pronoun you preferred to use? Did they just assume, or do they continue to refer to you by your birth sex?
22. Has caregivers identified support groups, places, and people for you outside of the family setting?

## APPENDIX K: PROVIDER NETWORK STANDARDS

This appendix summarizes the network standards and methodology for the MCO serving enrollees under this Contract. These standards represent experience in West Virginia and current practices, recent utilization, patterns of care, and provider network standards used by other state Medicaid programs. The intent of setting these standards is to ensure members have adequate access to all covered services.

### General Network Requirements

The MCO must establish and maintain provider networks in geographically accessible locations and in sufficient numbers to make all covered services available to the populations served in a timely manner. The information provided represents the minimum standards for the MCO's provider network. However, the MCO must ensure access to all services included in the MCO benefits package, even where a standard for the specialty type has not been defined.

As described below, the provider network standards for West Virginia's MCO program include provider-to-enrollee ratios and travel time and distance. The provider-to-enrollee ratios ensure that MCO provider networks have adequate capacity, while the travel time and distance standards establish choice and geographic accessibility of providers. Together, these standards ensure medical services are accessible throughout the State.

In order to meet access requirements, the MCO must meet the defined provider-to-enrollee ratios and time and distance standards in every county. In the calculating provider-to-enrollee ratios, the MCO may only count *unique providers* located within the county. For the time and travel standard, the MCO may count *all provider locations* within the county or within the appropriate travel time from the county border. Travel time and distance standards are measured from the enrollee's residence to the provider's location. Network standards are consistent across the counties.

### Medical Provider Access Standards

#### *Provider-to-Enrollee Ratios*

For all adult and pediatric populations served, the MCO must contract with a sufficient number of active providers in each county to meet the following standards.

Provider Type	Adult Standard	Pediatric Standard
PCP	One <b>(1) provider</b> for every five hundred <b>(500) enrollees</b> per county	One <b>(1) provider</b> for every two hundred fifty <b>(250) enrollees</b> per county
OB/GYN or certified nurse midwife	One <b>(1) provider</b> for every one thousand <b>(1,000) enrollees</b> per county	

#### *Medical Provider Network Time and Travel Distance*

The MCO must contract with a sufficient number of active providers accepting new patients to meet the following standards for all adult and pediatric populations. For review purposes, medical providers are grouped into the following categories: PCP, OB/GYNs, frequently-used specialists, other specialists, and hospitals. The requirements for each specialty group are outlined below.

Provider Category	Provider Type	Adult Standard	Pediatric Standard
PCP	PCP	Two (2) providers within twenty (20) miles or thirty (30) minutes travel time	Two (2) providers within twenty (20) miles or thirty (30) minutes travel time
OB/GYN	OB/GYN or certified nurse midwife	Two (2) providers within twenty-five (25) miles or thirty (30) minutes travel time	
Frequently-Used Specialist	Allergy	Two (2) provider within twenty (20) miles or thirty (30) minutes travel time	Two (2) provider within twenty (20) miles or thirty (30) minutes travel time
	Audiology	Two (2) provider within twenty (20) miles or thirty (30) minutes travel time	Two (2) provider within twenty (20) miles or thirty (30) minutes travel time
	Cardiology	Two (2) provider within twenty (20) miles or thirty (30) minutes travel time	Two (2) provider within twenty (20) miles or thirty (30) minutes travel time
	Dermatology	Two (2) provider within twenty (20) miles or thirty (30) minutes travel time	Two (2) provider within twenty (20) miles or thirty (30) minutes travel time
	General Surgery	Two (2) provider within twenty (20) miles or thirty (30) minutes travel time	Two (2) provider within twenty (20) miles or thirty (30) minutes travel time
	Gastroenterology	Two (2) provider within twenty (20) miles or thirty (30) minutes travel time	Two (2) provider within twenty (20) miles or thirty (30) minutes travel time
	Neurology	Two (2) provider within twenty (20) miles or thirty (30) minutes travel time	Two (2) provider within twenty (20) miles or thirty (30) minutes travel time
	Occupational Therapy	Two (2) provider within twenty (20) miles or thirty (30) minutes travel time	Two (2) provider within twenty (20) miles or thirty (30) minutes travel time
	Oncology	Two (2) provider within twenty (20) miles or thirty (30) minutes travel time	Two (2) provider within twenty (20) miles or thirty (30) minutes travel time
	Ophthalmology	Two (2) provider within twenty (20) miles or thirty (30) minutes travel time	Two (2) provider within twenty (20) miles or thirty (30) minutes travel time
	Orthopedics	Two (2) provider within twenty (20) miles or thirty (30) minutes travel time	Two (2) provider within twenty (20) miles or thirty (30) minutes travel time
	Orthopedic Surgeon	Two (2) provider within twenty (20) miles or thirty (30) minutes travel time	Two (2) provider within twenty (20) miles or thirty (30) minutes travel time
Otolaryngology / Otorhinolaryngology	Two (2) provider within twenty (20) miles or thirty (30) minutes travel time	Two (2) provider within twenty (20) miles or thirty (30) minutes travel time	

<b>Provider Category</b>	<b>Provider Type</b>	<b>Adult Standard</b>	<b>Pediatric Standard</b>
	Physical Therapy	Two <b>(2)</b> provider within twenty <b>(20)</b> miles or thirty <b>(30)</b> minutes travel time	Two <b>(2)</b> provider within twenty <b>(20)</b> miles or thirty <b>(30)</b> minutes travel time
	Pulmonology	Two <b>(2)</b> provider within twenty <b>(20)</b> miles or thirty <b>(30)</b> minutes travel time	Two <b>(2)</b> provider within twenty <b>(20)</b> miles or thirty <b>(30)</b> minutes travel time
	Physical Medicine and Rehabilitation Specialist	Two <b>(2)</b> provider within twenty <b>(20)</b> miles or thirty <b>(30)</b> minutes travel time	Two <b>(2)</b> provider within twenty <b>(20)</b> miles or thirty <b>(30)</b> minutes travel time
	Speech Therapy	Two <b>(2)</b> provider within twenty <b>(20)</b> miles or thirty <b>(30)</b> minutes travel time	Two <b>(2)</b> provider within twenty <b>(20)</b> miles or thirty <b>(30)</b> minutes travel time
<b>Other Specialist</b>	Anesthesiology	One <b>(1)</b> provider within twenty <b>(20)</b> miles or thirty <b>(30)</b> minutes travel time	One <b>(1)</b> provider within twenty <b>(20)</b> miles or thirty <b>(30)</b> minutes travel time
	Chiropractic	One <b>(1)</b> provider within twenty <b>(20)</b> miles or thirty <b>(30)</b> minutes travel time	One <b>(1)</b> provider within twenty <b>(20)</b> miles or thirty <b>(30)</b> minutes travel time
	Dialysis	One <b>(1)</b> provider within twenty <b>(20)</b> miles or thirty <b>(30)</b> minutes travel time	One <b>(1)</b> provider within twenty <b>(20)</b> miles or thirty <b>(30)</b> minutes travel time
	Durable Medical Equipment (DME)	One <b>(1)</b> provider within twenty <b>(20)</b> miles or thirty <b>(30)</b> minutes travel time	One <b>(1)</b> provider within twenty <b>(20)</b> miles or thirty <b>(30)</b> minutes travel time
	Endocrinology	One <b>(1)</b> provider within twenty <b>(20)</b> miles or thirty <b>(30)</b> minutes travel time	One <b>(1)</b> provider within twenty <b>(20)</b> miles or thirty <b>(30)</b> minutes travel time
	Hematology	One <b>(1)</b> provider within twenty <b>(20)</b> miles or thirty <b>(30)</b> minutes travel time	One <b>(1)</b> provider within twenty <b>(20)</b> miles or thirty <b>(30)</b> minutes travel time
	Home Health Services	One <b>(1)</b> provider within twenty <b>(20)</b> miles or thirty <b>(30)</b> minutes travel time	One <b>(1)</b> provider within twenty <b>(20)</b> miles or thirty <b>(30)</b> minutes travel time
	Laboratory	One <b>(1)</b> provider within twenty <b>(20)</b> miles or thirty <b>(30)</b> minutes travel time	One <b>(1)</b> provider within twenty <b>(20)</b> miles or thirty <b>(30)</b> minutes travel time
	Nephrology	One <b>(1)</b> provider within twenty <b>(20)</b> miles or thirty <b>(30)</b> minutes travel time	One <b>(1)</b> provider within twenty <b>(20)</b> miles or thirty <b>(30)</b> minutes travel time
	Neurosurgery	One <b>(1)</b> provider within twenty <b>(20)</b> miles or thirty <b>(30)</b> minutes travel time	One <b>(1)</b> provider within twenty <b>(20)</b> miles or thirty <b>(30)</b> minutes travel time
	Orthotics and Prosthetics	One <b>(1)</b> provider within twenty <b>(20)</b> miles or thirty <b>(30)</b> minutes travel time	One <b>(1)</b> provider within twenty <b>(20)</b> miles or thirty <b>(30)</b> minutes travel time

Provider Category	Provider Type	Adult Standard	Pediatric Standard
	Pathology	One (1) provider within twenty (20) miles or thirty (30) minutes travel time	One (1) provider within twenty (20) miles or thirty (30) minutes travel time
	Plastic Surgery	One (1) provider within twenty (20) miles or thirty (30) minutes travel time	One (1) provider within twenty (20) miles or thirty (30) minutes travel time
	Podiatry	One (1) provider within twenty (20) miles or thirty (30) minutes travel time	One (1) provider within twenty (20) miles or thirty (30) minutes travel time
	Radiology	One (1) provider within twenty (20) miles or thirty (30) minutes travel time	One (1) provider within twenty (20) miles or thirty (30) minutes travel time
	Thoracic Surgery	One (1) provider within twenty (20) miles or thirty (30) minutes travel time	One (1) provider within twenty (20) miles or thirty (30) minutes travel time
	Urology	One (1) provider within twenty (20) miles or thirty (30) minutes travel time	One (1) provider within twenty (20) miles or thirty (30) minutes travel time
Hospital	Basic Hospital Services	<b>Urban:</b> One (1) hospital within thirty (30) miles or forty-five (45) minutes travel time <b>Rural:</b> One (1) hospital within sixty (60) miles or ninety (90) minutes travel time	<b>Urban:</b> One (1) hospital within thirty (30) miles or forty-five (45) minutes travel time <b>Rural:</b> One (1) hospital within sixty (60) miles or ninety (90) minutes travel time
	Tertiary Hospital Services <sup>19</sup>	<b>Urban:</b> One (1) hospital within thirty (30) miles or forty-five (45) minutes travel time <b>Rural:</b> One (1) hospital within sixty (60) miles or ninety (90) minutes travel time	<b>Urban:</b> One (1) hospital within thirty (30) miles or forty-five (45) minutes travel time <b>Rural:</b> One (1) hospital within sixty (60) miles or ninety (90) minutes travel time

<sup>19</sup> Tertiary hospital services include (1) acute care services to pediatric patients in medical and surgical units; (2) obstetrics services; and (3) a neo-natal intensive care unit.

### Hospitals with Tertiary Services

Hospital Name	Pediatric Medical / Surgical Unit	Obstetrics Unit	Neonatal Intensive Care Unit
Beckley ARH	YES	NO	NO
Bluefield Regional	YES	NO	NO
CAMC - General Division	YES	YES	NO
CAMC - Memorial Division	YES	NO	NO
CAMC - Teays Valley (Putnam)	YES	YES	NO
CAMC - Women & Children's	YES	YES	YES
Cabell Huntington	YES	YES	YES
Camden-Clark Memorial	YES	YES	NO
Davis Memorial	YES	YES	NO
Fairmont General	YES	YES	NO
Grant Memorial	NO	YES	NO
Greenbrier Valley	YES	YES	NO
Jackson General	YES	NO	NO
Logan Regional	YES	YES	NO
Mon Health Medical Center	YES	YES	NO
Mon Health Preston Memorial Hospital	NO	YES	NO
Ohio Valley Medical Center	YES	YES	NO
Pleasant Valley	YES	YES	NO
Plateau Medical Center	YES	NO	NO
Pleasant Valley Hospital	YES	YES	NO
Princeton Community	YES	YES	NO
Raleigh General	YES	YES	NO
Reynolds Memorial	YES	YES	NO
Roane General Hospital	YES	NO	NO
Saint Francis Hospital	YES	NO	NO
St Joseph's Buckhannon	YES	YES	NO
St Mary's Medical Center	YES	YES	NO
Stonewall Jackson	NO	YES	NO
Summersville Memorial	YES	YES	NO
Thomas Memorial	YES	YES	YES
Webster County	YES	NO	NO
Weirton Medical Center	YES	YES	NO
Welch Community	NO	YES	NO
Wetzel County	NO	YES	NO
Wheeling Hospital	YES	YES	NO
Williamson Memorial Hospital	YES	NO	NO
WVU Hospitals	YES	YES	YES
WVU Medicine Berkeley Medical Center	YES	YES	NO
WVU Medicine Jefferson Medical Center	YES	YES	NO
WVU Medicine United Hospital Center	YES	YES	NO

### Pediatric Dental Network Access Standards

The MCO must contract with a sufficient number of active dental providers accepting new patients and meet the following standards for all pediatric populations. For review purposes, dental providers are grouped as dentists or dental specialists. The requirements for each specialty group are outlined below.

Provider Category	Provider Type	Pediatric Standard
General Dentist	Dentist	Two (2) providers within twenty-five (25) miles or thirty (30) minutes travel time
Dental Specialist	Oral Surgeon	One (1) provider within forty-five (45) miles or sixty (60) minutes travel time
	Orthodontist	One (1) provider within forty-five (45) miles or sixty (60) minutes travel time

### Behavioral Health Network Access Standards

The MCO must contract with a sufficient number of active behavioral health and SUD providers accepting new patients and meet the following standards for all adult and pediatric populations. For review purposes, behavioral health providers are grouped as behavioral health providers, behavioral health facilities, SUD providers, or SUD facilities. The requirements for each specialty group are outlined below.

Provider Category	Provider Type	Adult Standard	Pediatric Standard
BH Provider	Psychologist	Two (2) providers within forty-five (45) miles or sixty (60) minutes travel time	Two (2) providers within forty-five (45) miles or sixty (60) minutes travel time
	Psychiatrist	Two (2) providers within forty-five (45) miles or sixty (60) minutes travel time	Two (2) providers within forty-five (45) miles or sixty (60) minutes travel time
	Licensed Professional Counselor (LPC)	Two (2) providers within forty-five (45) miles or sixty (60) minutes travel time	Two (2) providers within forty-five (45) miles or sixty (60) minutes travel time
	Licensed Independent Clinical Social Worker (LICSW)	Two (2) providers within forty-five (45) miles or sixty (60) minutes travel time	Two (2) providers within forty-five (45) miles or sixty (60) minutes travel time
BH Facility	Adult Inpatient Psychiatric Unit	<b>Urban:</b> One (1) hospital within thirty (30) miles or forty-five (45) minutes travel time <b>Rural:</b> One (1) hospital within sixty (60) miles or ninety (90) minutes travel time	N/A

Provider Category	Provider Type	Adult Standard	Pediatric Standard
	Behavioral Health Clinic Psychiatric Residential Treatment Facility (PRTF)	<p>Contract with identified list:</p> <ul style="list-style-type: none"> <li>• Appalachian Community Health Center;</li> <li>• EastRidge Health Systems, Inc.;</li> <li>• FMRS Health Systems, Inc.;</li> <li>• Healthways, Inc.;</li> <li>• Logan-Mingo Area Mental Health, Inc.;</li> <li>• Northwood Health Systems, Inc.;</li> <li>• Potomac Highlands Mental Health Guild, Inc.;</li> <li>• Pretera Center for Mental Health Services;</li> <li>• Seneca Health Services, Inc.;</li> <li>• Southern Highlands;</li> <li>• United Summit Center, Inc.;</li> <li>• Valley Comprehensive Community Mental Health Center, Inc.; and</li> <li>• Westbrook Health Services, Inc.</li> </ul> <p>Contract with identified list:</p> <ul style="list-style-type: none"> <li>• Highland Charleston;</li> <li>• River Park; and</li> <li>• Barboursville’s School</li> </ul>	<p>Contract with identified list:</p> <ul style="list-style-type: none"> <li>• Appalachian Community Health Center;</li> <li>• EastRidge Health Systems, Inc.;</li> <li>• FMRS Health Systems, Inc.;</li> <li>• Healthways, Inc.;</li> <li>• Logan-Mingo Area Mental Health, Inc.;</li> <li>• Northwood Health Systems, Inc.;</li> <li>• Potomac Highlands Mental Health Guild, Inc.;</li> <li>• Pretera Center for Mental Health Services;</li> <li>• Seneca Health Services, Inc.;</li> <li>• Southern Highlands;</li> <li>• United Summit Center, Inc.;</li> <li>• Valley Comprehensive Community Mental Health Center, Inc.; and</li> <li>• Westbrook Health Services, Inc.</li> </ul> <p>Contract with identified list:</p> <ul style="list-style-type: none"> <li>• Highland Charleston;</li> <li>• River Park; and</li> <li>• Barboursville’s School</li> </ul>
	Psychiatric Residential Treatment Facility (PRTF)	N/A	<p>Contract with identified list:</p> <ul style="list-style-type: none"> <li>• Highland Charleston;</li> <li>• River Park; and</li> <li>• Barboursville’s School</li> </ul>
<b>SUD Provider</b>	Outpatient SUD provider	One <b>(1)</b> provider within forty-five <b>(45) miles</b> or sixty <b>(60) minutes</b> travel time	One <b>(1)</b> provider within forty-five <b>(45) miles</b> or sixty <b>(60) minutes</b> travel time
<b>SUD Facility</b>	Residential SUD provider	Contract with all SUD residential providers in West Virginia	N/A

## Essential Community Providers (ECPs)

Essential Community Providers (ECPs) are types of providers and settings that serve predominantly low-income and medically underserved populations such as Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). The MCO must contract with as many FQHCs and RHCs as necessary to permit beneficiary access to participating FQHCs and RHCs without having to travel a significantly greater distance past a non-participating FQHC or RHC. The requirements for FQHCs and RHCs are outlined below.

Provider Type	Adult Standard	Pediatric Standard
FQHC or RHC	One <b>(1)</b> provider within forty-five <b>(45) miles</b> or sixty <b>(60) minutes</b> travel time	One <b>(1)</b> provider within forty-five <b>(45) miles</b> or sixty <b>(60) minutes</b> travel time

## Network Adequacy for Additional Providers Types

The Department may identify additional providers when it promotes the objectives of the Medicaid program as determined by CMS. The MCO must contract with a sufficient number of these providers who are accepting new patients and must meet the following standards for all adult and pediatric populations. The requirements for additional providers are outlined below.

Provider Type	Adult Standard	Pediatric Standard
Additional Provider Type to promote the objectives of the Medicaid program as determined by CMS	One <b>(1)</b> provider within twenty <b>(20) miles</b> or thirty <b>(30) minutes</b> travel time	One <b>(1)</b> provider within twenty <b>(20) miles</b> or thirty <b>(30) minutes</b> travel time

## Network Submission and Network Adequacy Evaluation

In accordance with the preceding standards, the MCOs must submit to the Department the following provider network information as described below.

### Provider Network Submission

#### *Submission of Geographic Data Maps*

The MCO must provide individual geographic maps for all medical, dental, and behavioral health provider, ECP, and other provider types and subtypes defined in the preceding standards. Each map must either clearly demonstrate which providers are accepting new patients or only include providers that are accepting new patients.

The MCO must submit supporting data tables with each map. The supporting data tables must include, at a minimum, the name of county, the number of eligible enrollees in the county, the provider type, the number of providers of that type in the county, the number of enrollees with access to the provider type, the number of enrollees without access to provider type, the percentage of enrollees with access to the provider type, the percentage of enrollees without access to provider type, and the average distance to available providers.

The tables with the supporting data should follow each individual geographic data map. BMS will provide sample PDF and Excel formats for the geo maps and supporting data. The MCO must provide data for all provider types in both PDF and Excel formats.

The geographic data maps in PDF format and supporting tables in PDF and Excel by county for each provider type for which there is a defined time or distance standard must be submitted to the Department annually, by October 31<sup>st</sup>.

#### ***Submission of Provider Network File***

The MCO must submit to the Department annually by October 31<sup>st</sup> an Excel file listing all providers and facilities in the MCO's network for the Medicaid line of business only. Prior to submission, the Department will provide an Excel file template for the requested data. The files should contain the following information for **all** providers and facilities contracting with the MCO:

- Provider names listed in separate columns for last name, first name, middle initial, and degree
- Provider specialty
- Provider office names
- Provider type (e.g., physician, physician assistant (PA), nurse midwife, therapist, FQHC, psychologist, dentist)
- Provider addresses, including the county in which the provider office is located (list all provider locations, including out-of-state)
- Indicator for providers that are not accepting new patients
- Other provider restrictions, listed in separate columns by type of restriction (i.e., age restrictions, gender restrictions, or any other restrictions)
- Indicator for whether the physician acts as a PCP for physicians with primary care specialties (e.g., family practice, general practice, internal medicine, internal medicine, pediatrics)
- NPI and tax ID number, if available

The MCO may submit separate files for medical, dental, behavioral health, if preferred. Any network changes must be reported quarterly (forty-five (45) calendar days after end of the quarter) to the Department by specialty using the same format.

#### ***Submission of Ratio Worksheet***

The MCO must complete the provider-to-enrollee ratio worksheet for PCPs and OB/GYNs, using the Department-provided template. The Department-provided template contains instructions on which fields the MCO must populate. The MCO must submit the ratio worksheet to the Department annually by October 31<sup>st</sup>.

## **Provider Network Evaluation**

The Department will evaluate the provider-to-enrollee PCP and OB/GYN network adequacy ratios for the MCO in each county in which the MCO operates. In evaluating, The Department will compare the number of the MCO's unique providers located within the county to the number of the MCO's enrollees within the county.

To review compliance with time and travel distance standards, the Department will review geographic data maps and supporting tables to verify appropriate enrollee access to all provider types. BMS defines adequate access as one hundred percent (100%) of enrollees in each county have access to every provider type within the specified time and travel distance standards.

If any specialty services cannot be provided by a contracted provider, the MCO must demonstrate how it will ensure Medicaid enrollees access to this specialty (e.g., allowing out-of-network referrals when appropriate). The Department will evaluate the number and location of contracted specialists and provisions to ensure access where contracted specialists are not available in determining the overall adequacy of the specialist network in a given county.

The Department or its contractor will assess the network against the Department's network requirements and provide an assessment of network adequacy to the MCO in a timely manner.

### ***Exception Requests***

The Department will consider requests for exceptions to the provider access standards under limited circumstances (e.g. if no appropriate provider types are located within the mileage standards) and may, in its sole discretion, grant exceptions to these standards. Each exception request from the MCO to the Department must be in writing and include detailed information with supporting documentation regarding how they will mitigate the provider network deficit and meet the needs of the enrollees. Exceptions to network requirements will be considered based on the information provided, current patterns of care, and locations where the travel time and distance standards differ significantly from providers in the community