

CHAPTER 527 MOUNTAIN HEALTH TRUST (MANAGED CARE)

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BACKGROUND

[Mountain Health Trust](#) is the Bureau for Medical Services (BMS) managed care program that has been in operation since 1996. The purpose of the program is to improve access to high-quality health care for Medicaid members. Since being in place, the program has expanded significantly with respect to the number and categories of members required to enroll, the covered services included under managed care, and the geographic area covered.

The managed care program is authorized under a [1915\(b\) waiver](#), the Mountain Health Trust program waiver, which is the BMS agreement with the Centers for Medicare and Medicaid Services (CMS) regarding the terms under which its managed care program is implemented. The BMS [service provider agreement](#) (contract) with the Managed Care Organizations (MCOs) contains clauses ensuring compliance with all state and federal mandates as well as state programmatic initiatives and links to the MCO websites where more information for members and providers can be found, including handbooks for both groups. The waiver and MCO service provider agreement govern implementation of the program and requirements the MCOs must meet.

The BMS created a [Guide to Medicaid](#) to provide West Virginia Medicaid applicants and members with general information concerning Medicaid services and programs including managed care.

POLICY

527.1 MANAGED CARE OVERVIEW

For most Medicaid members, enrollment in an MCO is mandatory; however, some exceptions include but are not limited to Medicare dual eligible and those in residential settings or enrolled in certain Home and Community-Based Services (HCBS) waivers.

Generally, the MCO is responsible for providing most services covered under this policy manual. Covered services include medical, dental, and most behavioral health services. Excluded services include residential services, certain home and community-based waiver services, school-administered services as administered in [Chapter 538, School-Based Health Services](#), pharmacy with the exception of medications administered in a doctor's office or other medical facility, and early intervention services. MCOs must coordinate non-emergency transportation and certain other services although they are not responsible for providing these benefits.

527.2 COVERED MEMBERS

The following Medicaid members must enroll in an MCO:

- Children and their parents or other caretaker relatives;
- Adult [Medicaid expansion](#) members;
- Pregnant women; and
- Qualifying individuals receiving Supplemental Security Income (SSI).

The following Medicaid members are not eligible for enrollment in an MCO:

- Members enrolled in HCBS waivers except the Children with Serious Emotional Disorder Waiver (CSEDW)*;

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- Members in long-term care placement, i.e. nursing facilities and intermediate care facilities for individuals with intellectual disability (ICF/IID);
- Dual eligibles, i.e. those members eligible for both Medicare and Medicaid;
- Members in a period of retroactive eligibility, except for newborns; and
- Members receiving organ and tissue transplant services.

Please Note: These lists are not all inclusive. There may be exceptions to mandatory enrollment based on each individual circumstance. Enrollment is based on the category of eligibility.

*CSEDW services are covered through managed care under one contracted MCO. Please see [Chapter 502, Children with Serious Emotional Disorder Waiver \(CSEDW\)](#) for more information.

527.3 ELIGIBLE MANAGED CARE ENTITIES

Managed care entities administer medical, dental, and behavioral health services; establish and manage a credentialed provider network; conduct utilization management, quality management, member services, financial management, claims management; and maintain information systems.

To be eligible for participation in the West Virginia Medicaid managed care initiative, MCOs must:

- Enroll as a Medicaid provider;
- Be accredited by the National Committee for Quality Assurance (NCQA);
- Demonstrate network adequacy in the counties in which they participate;
- Obtain certificate of authority from the West Virginia Offices of the Insurance Commissioner; and
- Meet additional [federal](#) and state requirements, which include but are not limited to:
 - Developing quality and adequate networks, including provider credentialing and re-credentialing,
 - Maintaining financial solvency,
 - Adhering to restrictions on marketing to members,
 - Providing and coordinating required services, including promoting preventive care,
 - Providing member services and provision of information,
 - Providing encounter data and required reports,
 - Providing grievance and appeal options for members and providers,
 - Ensuring members' freedom of choice of provider, including special provisions related to certain services and continuity of care, and
 - Coordinating benefits for members with other insurance coverage.

527.4 COVERED SERVICES

There are two benefit plans that West Virginia Medicaid members are assigned. The benefit plan that a member is assigned depends on the member's eligibility category and medical needs.

- **Alternative Benefit Plan:** Applies to most Medicaid expansion members who are not medically frail. See [Chapter 400, Member Eligibility](#) for additional information.
- **Traditional Benefit Plan:** Applies to all other managed care members and Medicaid expansion members deemed medically frail, this plan can be found in the [Guide to Medicaid](#).

Certain services are not covered as [managed care benefits](#), but must be coordinated by the MCO including, but not limited to, non-emergency transportation and certain out-of-network services.

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The MCOs may provide value-added 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 members. Examples of such services can be found on the [value-added grid](#).

527.4.1 General Requirements for Covered Services

General requirements include, but are not limited to:

- Services must be medically necessary and associated documentation must be maintained;
- The [BMS Medicaid Provider Manual](#) is the source of authority for defining minimum state plan covered services;
- Providers must obtain all necessary service authorizations as specified by the MCO; and
- Members must follow MCO requirements with respect to choice of providers and coordination of benefits.

527.4.2 Care Management

The MCO must put in place care management systems with respect to medical and behavioral health services.

527.5 PROVIDER OVERVIEW

527.5.1 Provider Enrollment

The MCOs are responsible for contracting and credentialing their participating providers. MCOs must establish standards for providers that participate in their networks that must meet or exceed those for traditional Medicaid fee-for-service providers as outlined in [Chapter 300, Provider Participation Requirements](#). To enroll with a participating MCO, providers must contact the MCO directly.

Under [Section 5005\(b\)\(2\) of the 21st Century Cures Act](#), West Virginia Medicaid must require that a provider in a managed care network is enrolled with West Virginia Medicaid consistent with section 1902(kk) of this Title. Enrollment of the managed care provider must include provision of the provider's identifying information, including the name, specialty, date of birth, Social Security Number, National Provider Identifier (NPI) Number, Federal Tax ID Number, and the state license or certification number of the provider. Each provider must execute a provider agreement with West Virginia Medicaid and all applicable screening must be performed prior to contracting with the MCOs.

The contracted MCOs shall also follow any additional requirements for provider enrollment as established by West Virginia Medicaid ([42 CFR 438.214](#)).

527.5.2 Network Adequacy

Networks must be adequate with respect to geographic and specialty distribution, including primary care providers. Adequacy is measured by [federal regulations](#) and state service provider agreement criteria.

These networks must be comprised of hospitals, primary care providers (PCPs), dental, and specialty care providers 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.

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The MCO must contract with sufficient numbers of providers to maintain sufficient access in accordance with the BMS Medicaid managed care network standards for all enrollees, including those with limited English proficiency or physical or mental disabilities. The MCO must submit written documentation of the adequacy of its provider network as set forth in this Contract, at the time the MCO enters into a Contract with BMS; 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 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 BMS) to covered services (including the appropriate range of preventive, primary care, and specialty services) and to meet the needs of the population served.

MCOs must assure accessibility for those with disabilities by complying with the American with Disabilities Act (ADA) and also applying the same requirements to their providers. MCOs are required to encourage and foster cultural competency to their providers.

527.5.3 Provider Contracts

MCOs must develop contracts with their providers that:

- Reflect all federal and state requirements including, but not limited to:
 - Provider termination;
 - Required provider disclosures including business ownership;
 - Maintaining adequate malpractice insurance;
 - Requirement for provider reporting and return of overpayment;
 - Prohibitions on imposing any additional charges on the member above the Medicaid allowable reimbursement amount; and
 - Maintaining appropriate documentation
- Include negotiated reimbursement that may include certain innovative payment arrangements;
- Include grievance procedures for the members to abide by

527.5.4 Provider Services

MCOs must support providers in a variety of areas including, but not limited to, prior authorizations, billing and claims issues, grievances, and interpretation of covered services. To accomplish this, the MCOs must have a:

- provider services unit,
- provider call line,
- provider handbook, and
- provider directory.

Providers are responsible for verifying members' eligibility either through the fiscal agent's website, wvmmis.com, or the automated voice response system.

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527.5.5 Primary Care Providers (PCPs)

Only practitioners enrolled with certain specialties may serve as primary care providers, specifically internal medicine, family medicine, pediatrics, general medicine, and obstetrics/gynecology.

PCP responsibilities include, but are not limited to:

- Providing 24-hour, seven-day-a-week access;
- Coordinating referrals for specialty visits and other services as required by the MCO;
- Adhering to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Periodicity Schedule for members under 21 (See [Chapter 519 Practitioner Services, Policy 519.8, Evaluation and Management Services](#)); and
- Enhanced service coordination.

527.6 MEMBER OVERVIEW

527.6.1 Member Enrollment

Information about general Medicaid eligibility as well as managed care enrollment can be found in [Chapter 400, Member Eligibility](#).

For covered populations, enrollment in an MCO is mandatory. West Virginia contracts with an [enrollment broker](#) to work with members to ensure enrollment into an MCO and assignment of a PCP. Members have freedom of choice to select any MCO serving the county in which they reside. Information about the MCOs available in each county is available at www.mountainhealthtrust.com/compare-plans. If the member does not select an MCO, the enrollment broker automatically enrolls the member in a plan. MCOs must adhere to federal and state marketing restrictions governing their interactions with members. Once a member has selected an MCO, they must select a PCP within the MCO's Provider Network. Members also have freedom of choice with respect to PCP selection. If no PCP selection is made, or the selected PCP's panel is closed, the MCO must assist the member in making a final selection. MCOs will have 10 days to make a PCP assignment once the member is enrolled. Members may change MCOs and PCPs within prescribed rules.

527.6.2 Freedom of Choice

In addition to having the right to choose an MCO and a PCP, members may use out-of-network providers and/or see providers without a referral for services related to:

- Emergency care
- Family planning
- Continuity of care as defined by [42 CFR 438.208](#) and the [Service Provider Agreement](#) between BMS and the MCOs.

527.6.3 Member Services Requirements

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Each MCO must have a Member Services department to provide information about, and assistance with, the following areas:

- Covered services;
- Specialty services;
- Provider choice and how to change;
- Disenrollment;
- Grievances;
- Continuity of care;
- Confidentiality of medical information;
- New member orientation;
- Wellness education; and
- Member responsibility for payment for non-covered services.

Each MCO must develop a member handbook with information about these and other topics which can be found on each MCO's website accessible through the [BMS Managed Care website](#).

Each MCO must maintain a provider directory on its website including a list of available primary care providers.

527.6.4 Member Responsibilities

Members must take all actions necessary to meet MCO and Medicaid requirements including, but not limited to:

- Choosing a provider who is enrolled with the MCO; and
- Providing third party payer information if the member has insurance other than Medicaid.

527.6.5 Member Appeals and Grievances

The MCO's grievance and appeals procedures must be understandable and accessible to Medicaid enrollees and must comply with [federal requirements](#) and West Virginia Statutes [33-25A-12](#). Each MCO may have only one level of appeal for enrollees.

Medicaid enrollees 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 action 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.

A detailed description of the MCO's enrollee grievance and appeal procedure must be included in the member handbook provided to enrollees.

527.7 MCO REIMBURSEMENT

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West Virginia reimburses MCOs under full risk capitation service provider agreements. Rates must meet federal requirements for actuarial soundness. These rates are governed by the state's service provider agreements with the MCOs. There may be certain modifications to payments, e.g. for newborns.

527.8 QUALITY AND PERFORMANCE IMPROVEMENT

527.8.1 External Quality Review Organization (EQRO)

The State contracts with an external quality review organization (EQRO). The State's EQRO conducts an annual on-site review of each MCO's administrative and operational system to ensure that the MCO has the appropriate structure in place to meet all program requirements. Compliance with service provision requirements regarding family planning services, emergency care services, and FQHC-based services are part of the review. The EQRO conducts document review and in person interviews as part of its review of the following areas:

- Member rights and responsibilities
- Grievance system
- Quality assessment and performance improvement
- Provider network availability and accessibility
- Credentialing and re-credentialing
- Utilization management
- Health information system
- Utilization review
- Medical records
- Member experience

527.8.2 Quality Assessment and Performance Improvement (QAPI)

The MCOs are required to conduct performance improvement projects designed to achieve significant and sustained improvement in clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and member satisfaction. MCOs must analyze and report on the results.

Clinical focus areas include prevention strategies, improved care of acute or chronic conditions, high volume and high-risk care, and coordination and continuity of care. Non-clinical focus areas include availability, accessibility, and cultural competency of services; management of complaints; quality of patient encounters; and patient communication.

527.9 MOUNTAIN HEALTH PROMISE (SPECIALIZED MANAGED CARE PROGRAM FOR CHILDREN AND YOUTH)

The [Mountain Health Promise](#) is a specialized managed care program for children and youth in foster care or the adoption assistance program. The intent of this program is to improve the care coordination for medically and socially necessary services to the population served. The covered population is automatically enrolled in the contracted specialized MCO and receive notification of the option to disenroll into fee-for-service (FFS).

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GLOSSARY

Definitions in [Chapter 200, Definitions and Acronyms](#) apply to all West Virginia Medicaid services, including those covered by this chapter. Definitions in this glossary are specific to this chapter.

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

Caretaker Relative: Someone who assumes primary responsibility for a child's care, in a place established as the relative's home. A specified caretaker relative includes: natural or adoptive parents; blood relatives (those of half-blood, brothers/sisters, grandparents, great-grandparents, great-great grandparents, great-great-great grandparents, uncles/aunts, great-uncles/aunts, great-great uncles/aunts, nephews/nieces, first cousins, first cousins once removed); legal step-relatives (step-parents, step-brother/sister, step-grandparents, step-great-grandparents, step-great-great-grandparents, step-great-great-great-grandparents, step-uncles/aunts, step-great-uncles/aunts, step-great-great-uncles/aunts, step-nephews/nieces, step-first cousins, step-first cousins once removed); the specified relationship exists even though the marriage terminated in death or divorce. Must not be the new spouses of step-relatives.

Care Management: Coordination of benefits and services to assist Medicaid members in achieving access to needed care, in navigating their way through complex systems, and increasing the management and advocacy skills of Medicaid members necessary to become informed and engaged.

Covered MCO Services: Health care services the MCO must arrange to provide to Medicaid members, including all services required by the service provider agreement and state and federal law.

Emergency Care: Includes inpatient and outpatient services needed immediately and provided by a qualified Medicaid provider for emergency medical 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 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.

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.

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 service provider agreement.

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External Quality Review Organization (EQRO): The entity contracted by the West Virginia Department of Health and Human (DHHR) Services to conduct periodic independent studies regarding the quality of care delivered to West Virginia Medicaid managed care members.

Enrollment Broker: The entity contracted by the DHHR to conduct outreach and enrollment of eligible West Virginia Medicaid managed care members.

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 infections (STIs) 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.

Healthcare Effectiveness Data and Information Set (HEDIS): A set of standardized performance measures developed, sponsored, and maintained by NCQA which are designed to reliably compare the performance of managed care health plans.

Managed Care Organization (MCO): A Health Maintenance Organization licensed to do business in the State of West Virginia, which is the entity providing services under the agreement.

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.

MCO Appeal: A request for a review of the MCO's action as defined in this contract and 42 CFR 438.400(b) (1-6).

MCO Formal Grievance: A written expression of dissatisfaction other than those subject to appeal.

MCO 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 actions 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.

MCO Grievance Process: The procedure for addressing a member's grievances and complaints.

MCO Grievance System: Includes a grievance process, an appeals process, and access to the State's fair hearing system.

MCO Informal Grievance: An oral expression of dissatisfaction other than those subject to appeal.

Medically Necessary Services: Services and supplies that are appropriate and necessary for the symptoms, diagnosis, or treatment of an illness. They are provided for the diagnosis or direct care of an illness within the standards of good practice and not for the convenience of the plan, member, caregiver,

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or provider. The appropriate level of care can be safely provided and the most efficient and cost-effective services/supplies to meet the member's need.

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. The BMS Provider Manual can be found on the [BMS website](#).

Medical Loss Ratio (MLR): The ratio of the sum of total medical expenses and the total capitation revenue, including monthly capitation and delivery kick payments, received by the MCO and subject to any applicable adjustments.

Mountain Health Promise (MHP): West Virginia's full-risk managed care program administered by BMS that provides statewide physical and behavioral health services to children and youth in the foster care system and individuals receiving adoption assistance.

Mountain Health Trust (MHT): West Virginia's Medicaid mandatory managed care program administered by BMS aiming to improve access to high-quality health care for Medicaid members by emphasizing the effective organization, financing, and delivery of primary health care services.

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

Non-Emergency Services: Any care or services that are not considered emergency services as defined in this chapter. 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.

MCO Primary Care Provider (PCP): A specific clinician responsible for providing routine care for health promotion and maintenance, and coordinating the health care needs of members.

MCO Prior Authorization: Prior approval necessary for specified services to be delivered for an eligible member by a specified provider before services can be performed, billed, and payment made. It is a utilization review method used to control certain services that are limited in amount, duration, or scope.

Out-of-Network Provider: Provider who has not contracted with a managed care organization for reimbursement at a negotiated rate.

Safety Net Provider: Provider who offers a combination of comprehensive medical and enabling services targeted to underinsured, uninsured, and low-income populations.

Third-Party Liability (TPL): The legal obligation of third parties (e.g., certain individuals, entities, insurers, or programs) to pay part or all of the expenditures for medical assistance furnished under a Medicaid state plan. By law, all other available third-party resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid.

REFERENCES

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The managed care website can be [here](#).

The 21st Century Cures Act can be accessed [here](#).

The enrollment broker website can be found [here](#).

Federal regulations governing Medicaid managed care can be found in [42 CFR 438](#).

The 1915(b) Waiver is located on the [BMS Waiver Approval webpage](#).

CHANGE LOG

REPLACE	TITLE	EFFECTIVE DATE
New Chapter	Mountain Health Trust (Managed Care)	April 1, 2018
Entire Chapter	Minor grammatical changes throughout 527.1 Managed Care Overview: Updated language defining which pharmacy benefits are non-covered services 527.2 Covered Members: Removed children in foster care from excluded covered members 527.5.1 Provider Enrollment: Updated section 527.9 Mountain Health Promise: Added section	November 1, 2020