

**WEST VIRGINIA BUREAU FOR MEDICAL SERVICES
MEDICAID MCO PROVIDER APPLICATION
SFY 2020**

DRAFT

Draft and Confidential

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Please note that all MCO Application and related materials are provided for informational purposes only. Any interested MCO must work with BMS to establish a timeline and receive the most current documents.

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INSTRUCTIONS

The MCO application must contain a response to each of the questions below. Responses must be in compliance with the West Virginia Medicaid program requirements as described in the MCO contract. The applying MCO must be prepared to discuss their responses and answer any follow-up questions. An on-site review will be scheduled prior to contracting. A sample on-site review agenda may be found in Attachment A.

In addition, the MCO must also submit a copy of all materials submitted to the West Virginia Insurance Commissioner in accordance with the Health Maintenance Organization Application for Certificate of Authority. These materials will be assumed to apply to the Medicaid line of business and will be incorporated into the review and into the contract by reference.

Applicants will submit one hard copy and one electronic copy of the materials submitted to the Insurance Commissioner and the materials specified below in the MCO Provider Application to The Lewin Group (a BMS contractor) and one copy to Jeff Wiseman at DHHR as soon as completed:

West Virginia DHHR
Attention: Jeff Wiseman
1 Davis Square, Suite 100 E
Charleston, WV 25301-3708
304-558-6052
Jeff.A.Wiseman@wv.gov

The Lewin Group
Attention: West Virginia Medicaid
3130 Fairview Park Drive, Suite 500
Falls Church, VA 22042
WV.Medicaid@lewin.com

Responses should be formatted in the same order as the application below, with clear question references to allow for ease in reviewing. If you have any questions, please email The Lewin Group at WV.Medicaid@Lewin.com.

Please note that while some questions may not be currently applicable (e.g. administration of pharmacy services), the State still requests that the MCO provide information on how the program would be administered should it covered in the future.

I. ORGANIZATIONAL/MANAGEMENT INFORMATION

Please provide the following:

- Corporate (legal) name, headquarters mailing address, street address, telephone number, fax number, and tax identification number;
 - Name, mailing address, street address, telephone number, and fax number of business unit that will administer this contract, if different from above; and
 - Name of contact person for this contract.
1. Please provide an organizational chart (Chart 1) showing the corporate structure, lines of responsibility, and authority in the administration of the MCO's business as a health plan; and an organizational chart (Chart 2) showing the West Virginia organizational structure and how it relates to the proposed Service Area(s), including staffing and functions performed at the local level. The organizational Chart 2 shall include the names, titles, and contact information for the following key staff positions or functions: Medicaid Line of Business Manager, Medicaid Administrator/Contract Liaison, Chief Financial Officer, Compliance Officer, Medical Director, Medical Management (Utilization Review/Care Management) Director, Care Management Director, Quality Director, Member Services Director, Claims Payment Director, Provider Relations/Network Director, Community Engagement Specialist, Socially Necessary Services Liaison, and Information Technology Director. This chart should also indicate the reporting relationships of each of the individuals listed. Provide names and contact information for key personnel who will be assigned to this contract as available. Indicate the city and state where each position will be located.
 2. Submit a brief narrative explaining the organizational charts submitted, and highlighting the key functional responsibilities and reporting requirements of each organizational unit relating to the MCO's proposed management of the MCO program(s), including its management of any proposed subcontractors.
 3. Provide information on how MCO staffing numbers will change to service the WV Medicaid benefit.
 4. Provide a hiring plan for WV Medicaid contract administration.

5. Please provide the names of the manager of the West Virginia Medicaid line of business and the Medicaid Administrator/Contract Liaison. If either individual is to be hired in the future, provide an approximate time line for appointment. Provide a current organizational chart for the business unit that will administer the Medicaid line of business. The organizational chart shall include the names, titles, and contact information for the following key staff positions or functions: Medicaid Line of Business Manager, Medicaid Administrator/Contract Liaison, Chief Financial Officer, Medical Director, Medical Management (Utilization Review/Care Management) Director, Quality Director, Member Services Director, Claims Payment Director, Provider Relations Director, Community Engagement Specialist, Socially Necessary Services Liaison and Information Technology Director. This chart should also indicate the reporting relationships of each of the individuals listed.
6. Provide resumes of the manager of the West Virginia Medicaid line of business and the Medicaid Administrator/Contract Liaison. If either individual is to be hired in the future, provide an approximate timeline for appointment and job descriptions.
7. MCOs are required to have a Medicaid Administrator/Contract Liaison with substantial experience in health care, experience working with low-income populations, and cultural sensitivity. Define the timeframe for initiating and completing training of the Medicaid Administrator/Contract Liaison. Describe any additional training or materials the MCO will provide to the Member Administrator/Contract Liaison to support the enrollment of the foster care population.
8. Submit a copy of the MCO's Certificate of Authority from the Office of the Insurance Commissioner and a copy of all materials submitted to the West Virginia Insurance Commissioner in accordance with the Health Maintenance Organization Application for Certificate of Authority.
9. Provide a list of all counties for which the MCO intends to serve enrollees and indicate whether the MCO has received approval from the Department of Insurance to serve Medicaid enrollees in each county (note: all counties must be served under the foster care contract).
10. Provide the type of ownership of the MCO by its ultimate parent company:
 - Wholly-owned subsidiary of a publicly-traded corporation;
 - Wholly-owned subsidiary of a private (closely-held) stock corporation;
 - Subsidiary or component of a non-profit foundation;

- Subsidiary or component of a governmental entity;
- Independently-owned member of an alliance or cooperative network;
- Joint venture (describe ultimate owners);
- Stand-alone privately-owned corporation (no parents or subsidiaries); or
- Other (describe).

Describe the legal status of the MCO and its parent company.

11. Please provide the following information in accordance with 42 C.F.R. § 455.104:

- a) The name and address of any person (individual or corporation) with an ownership or control interest in the MCO. The address for corporate entities must include as applicable the primary business address, every business location, and the P.O. Box address. Date of birth and Social Security Number (in the case of an individual);
- b) Tax identification number for a corporation with an ownership or control interest in the MCO or in a subcontractor in which the MCO has a 5 percent or more interest;
- c) Whether the person (individual or corporation) with ownership or control interest in the MCO and/or subcontractor is related to any other person with ownership or control interest such as a spouse, parent, child, or sibling;
- d) 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
- e) The name, address, date of birth, and Social Security Number of an agent or a managing employee of the MCO.

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

Provide the same information for any proposed subcontractors.

13. Provide the number of current Medicaid enrollees in other states, by state. Describe any experience managing services for members in other Medicaid programs or other lines of business within West Virginia.

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

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

16. Please submit a completed copy of the following table:

Medicaid Administrative Function	Location (City/State)	In-House or Contracted Out?	Other Lines of Business Supported				
			Medicare	Medicaid (list states)	S-CHIP (list states)	Other _____	Other _____
Manager, Medicaid line of business		In-house					
Medicaid Administrator/ Contract Liaison		In-house					
Member services							
Provider contracting							
Provider relations							

Medicaid Administrative Function	Location (City/State)	In-House or Contracted Out?	Other Lines of Business Supported				
			Medicare	Medicaid (list states)	S-CHIP (list states)	Other _____	Other _____
Utilization management							
Care management							
Claims processing							
Other _____							

17. If the MCO retains a subcontractor for claims processing, pharmacy benefit management (PBM), dental benefits management (DBM), behavioral health management, utilization management, or network development, describe the subcontractor monitoring plan, including activities and monitoring tools of such subcontractor. Provide subcontractor agreements for review and approval.

18. Provide an organizational chart for subcontractors demonstrating how the subcontractor(s) will be managed within the MCO's WV organizational structure, including the primary individuals at the MCOs organization and at each subcontractor organization responsible for overseeing such subcontract. This information may be included in Chart 2 or in a separate organizational chart(s).

19. If contracting with a PBM or other benefits manager, provide a separate listing/table of PBM functions vs. MCO functions in administering the pharmacy and/or other benefit (e.g., recruitment, member calls, provider education)

20. If not provided within a subcontractor monitoring plan, identify types of reports/data that will be provided to the MCO, from the subcontractor, to help manage the medical, pharmacy, or any other benefit. Indicate the overall content of reports and the frequency with which they will be provided to the MCO. Please provide sample reports where available.

21. If not provided within a subcontractor monitoring plan, provide a description of how the MCO will use reports/data from the subcontractor to ensure appropriate vendor oversight and beneficiary access/satisfaction/continuity of care.
22. If not provided within a subcontractor monitoring plan, identify the frequency of contact/status calls with the subcontractor upon go-live and on an ongoing basis.
23. Describe a plan that will be followed in the event that the subcontractor does not fulfill its contract or service obligations including details on any corrective action plan processes.
24. Describe the MCO's contingency plan in the event that the MCO or the subcontractor terminates its contract, including plans to identify another subcontractor and transition steps that would take place to ensure uninterrupted beneficiary access.
25. Describe whether each subcontractor is an affiliate of the MCO or an unrelated third party.
26. Describe each subcontractor's corporate background and experience, including its estimated annual revenues from unaffiliated parties, number of employees, location(s), and identification of three (3) major clients.
27. Describe any screening processes designed to ensure that the MCO does not subcontract with entities that are prohibited, suspended, or excluded from participating in Medicare, Medicaid, or other federal health care programs. See 42 C.F.R. § 455 et.seq. as a reference to what minimum screenings are required.
28. Provide a written draft of the MCO's Fraud and Abuse Compliance Plan.
29. Submit for review employee False Claims training in fraud and abuse detection, prevention, and reporting.
30. Submit for review any Value-Added Services to be offered.

31. Provide a high-level description of the records retention process.

II. NETWORK DEVELOPMENT

32. Provide a general recruitment plan describing the mechanisms the MCO/PBM/other benefits manager will use to build network access. The plan must also describe methods the MCO/PBM/other benefits manager will use to monitor and evaluate ongoing access to services (e.g., time/distance, appointment timeliness)
33. Describe efforts the MCO has made or will make to contract with providers who currently serve Medicaid foster care members including providers with experience and expertise in treating populations with special health care needs. Please address multiple types of providers (e.g., physicians and other providers, facilities, pharmacies). Also include residential treatment facilities and socially necessary service providers.
34. Describe the process for ensuring access to the full range of specialty and facility service providers for members with complex needs.
35. Describe MCO methods to ensure beneficiary access to covered services in areas where the provider network standards do not require a specialist (e.g., physical medicine and rehabilitation providers, geriatricians, hospice facilities)
36. Describe the recruitment strategy for specialty care providers and hospitals.
37. Describe the recruitment strategy for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). If the MCO does not intend to contract with these providers, please describe how the MCO will ensure that members can access these providers.
38. Describe the recruitment strategy for the publicly-supported providers listed below. If the MCO does not intend to contract with these providers, please describe how the MCO will ensure that members can access these types of services.

- a) Local Health Departments
 - b) Critical Access Hospitals
 - c) Primary Care Centers
 - d) School-Based Health Centers
 - e) Right from the Start (RFTS) providers
 - f) Bureau for Public Health Laboratories
 - g) Children with Special Health Care Needs (CSHCN) Program
39. Provide a description of the MCO monitoring process for the PCP panels. Note that the Bureau for Medical Services requires a limit of no more than 2,000 Medicaid enrollees assigned per PCP.
40. Submit network documentation and geographic mapping reports in accordance with the instructions for the Medicaid network standards.
41. Provide what specialists will be able to serve as a PCP. Describe the circumstances and process under which a member may select a specialist as his/her primary care provider, including any MCO approvals required, and describe any restrictions on the types of specialists that can serve as PCPs for foster care members or other members with complex needs.
42. Describe how the MCO/PBM will ensure that the contracted network has a suitable range of therapies to meet beneficiary needs, including the availability of compounds and specialty drug pharmacies.

43. Describe any additional efforts MCO/PBM will make to outreach to high volume or rural pharmacies.
44. Describe how the MCO/PBM will ensure that pharmacy services are available to members in a timely manner, including nights and weekends.
45. Submit for review provider credentialing policies and procedures. If different for pharmacy providers, please indicate.
46. Describe the provider re-credentialing cycle. If different for pharmacy providers, please indicate.
47. Submit the training curriculum for MCO/PBM provider enrollment and credentialing teams for review.
48. Submit the draft provider directory for review. (To be submitted at later date. Timeframes and guidance to be provided by BMS.)
49. Submit the standard provider contract templates for review (PCPs, specialists, hospitals, pharmacy).
50. Submit the provider disclosure forms (templates only, de-identified) for review. See 42 C.F.R. §§ 455.104,105, 106.

III. MEMBER SERVICES

51. Describe the MCO's process for developing materials for members, including members with special health care needs (e.g., consulting with persons with disabilities, advocacy groups).
52. Submit the member handbooks for review. (To be submitted at a later date. Guidance and timelines will be provided by BMS.)

53. Submit the MCO.com website content for WV Medicaid for review. (To be submitted at a later date. Guidance and timelines will be provided by BMS at a later date.)
54. Submit the marketing plan for review. (To be submitted at a later date. Guidance and timelines will be provided by BMS.)
55. Submit MCO/PBM grievance and appeals acknowledgement letters and resolution letters for review. (To be submitted at a later date. Guidance and timeline will be provided by BMS.)
56. Submit adverse determination letters including Fair Hearing rights for review. (To be submitted at a later date. Guidance and timelines will be provided by BMS.)
57. For members who do not indicate a PCP preference at the time of enrollment, describe the MCO's process for notifying the member of PCP assignment, educating members of the right to change PCPs, and any follow-up communications the MCO will conduct to ensure that the member is aware of the assignment.
58. Submit sample letters notifying members of the PCP assignment for review. (To be submitted at a later date. Guidance and timelines will be provided by BMS.)
59. Provide a copy of the explanation of benefits (EOB) form if used by MCO/PBM.
60. Provide a description of any outreach and transition planning efforts directed toward beneficiaries with special health care needs who are identified through the enrollment broker's health assessment. Describe if outreach will be conducted via telephone or mail.
61. Describe how members will be made aware of available community resources and social services (e.g., member handbook, newsletter, case managers).
62. Provide a timeline with mailing dates for member materials. (To be submitted at a later date. Guidance and timelines will be provided by BMS.)

63. Provide the turnaround time for mailing, on an ongoing basis, the new member handbook, updates to handbooks, and handbooks requested ad hoc by a member.
64. Submit grievance policies and procedures for review.
65. Provide MCO/PBM grievance and appeals process flow-chart, including the turnaround time and levels of authority for review.
66. Describe the MCO's plan to provide enabling services, such as providing assistance with complaints and grievances, to members with physical or developmental disabilities. How will the Medicaid Administrator/Contract Liaison monitor grievances?
67. Indicate how members will be able to contact the MCO/PBM member services department (e.g., hours of operation, emergency hotline, toll-free number).
68. Submit the number for the MCO's member services hotline.
69. Submit the process and guidelines for transferring calls between the MCO and subcontractors (e.g., PBM) for review, if applicable.
70. Submit call transfer protocols and decision trees for the MCO's member services hotline for review.
71. MCOs may employ a Medicaid Member Advocate who has substantial experience in health care, experience working with low-income populations, and cultural sensitivity. Describe on what specific topics, including those that support enrollment of individuals with special health care needs, the Medicaid member advocate will be prepared to address (e.g., assistance with resolving access issues, obtaining materials in alternate formats, receiving assistance with grievances and appeals, promoting continuity of care). Provide the timeframe for initiating and completing training of the Medicaid Member Advocate as well as copies of the training curricula. Please provide copies of the training materials that the MCO will provide to the Medicaid Member Advocate.

72. How will the Medicaid Member Advocate be evaluated in regard to meeting and addressing foster care members' needs?
73. Provide advance directive policies and procedures, including procedures for:
 - Informing enrollees of their right to make advance directives;
 - Providing physicians and members with appropriate forms or guidance; and
 - Ensuring that advance directives are maintained in enrollees' medical records.
74. Describe how members are educated about the ability to request out-of-network referrals (e.g., member handbook). Include a description of how member services representatives are educated on the referral process.
75. Submit for review MCO/PBM training curriculum for member services staff on WV Medicaid program requirements. Please specify whether the training curriculum addresses serving members with special health care needs. Describe how the MCO will train member services representatives on serving members with disabilities and chronic conditions, the culture of disability, and the resources available to members.
76. Submit training curriculum, including frequency of trainings, for staff that perform outreach to members with special health care needs upon enrollment.
77. Describe the customer service performance standards the MCO/PBM uses (e.g., member-to-representative ratios, call answering time, turn-around time for member requests) and the standards that will apply to the Medicaid program (i.e. call abandonment rate not to exceed 5%, single contact resolution, 83% of calls answered in 30 seconds).
78. Discuss the MCO's new member enrollment and education process, including member contact, from the time of initial notification of the member's enrollment by the enrollment broker through the first month of actual enrollment. During initial enrollment, describe the MCO's steps and timeframes for:

- Contacting members (e.g., welcome calls or letters, home visits);
 - Reaching out to members who are difficult to contact (e.g., disabled members, members without telephones);
 - Processing and issuing identification cards; and
 - Distributing Medicaid member handbooks.
79. Submit for review a sample member ID card. (To be submitted at a later date. Guidance and timelines will be provided by BMS.)
 80. Submit for review the policy on disenrollment of members.
 81. Submit for review the initial PCP assignment process and procedures for handling PCP assignment/change.
 82. Submit for review a description of methodology for a PCP assignment. Provide member characteristics (i.e. claims history, proximity), particularly for new members when auto-assigning to a PCP. Describe any restrictions on the types of specialists that can serve as PCPs for members with complex needs.
 83. Submit for review call transfer protocols and decision trees for the MCO and/or PBM member services hotline. Submit a PA (72h emergency prescription medication dispense) call flow separately.
 84. Submit for review the pharmacy lock-in assignment process and procedures for handling changes.

85. Submit for review the pharmacy lock-in notification letter (To be submitted at a later date. Guidance and timelines will be provided by BMS.)
86. Describe the process of how PDL and formulary changes affecting members' care will be distributed to the members. Include timeframes and methods of delivery.

IV. PROVIDER SERVICES

87. Submit for review provider manuals. (To be submitted at a later date. Guidance and timelines will be provided by BMS.)
88. Describe the process of how the MCO/PBM/behavioral health/dental provider manuals will be distributed, including timeframes and methods of delivery.
89. Submit for review the schedule for provider training and webinars during the implementation phase.
90. Submit for review the process, schedule, and content for providing ongoing training to existing providers.
91. Submit for review the MCO/PBM process for handling provider complaints and appeals, including those related to credentialing, claims, authorization and other complaints and appeals as applicable.
92. Describe the MCO/PBM's capabilities to accept and pay claims on time. Provide a claims turnaround report for each of the past 12 months, indicating the percentage of total claims that are clean, and the percentage of clean claims processed within 30 days and within 90 days. If any aspect of claims processing is contracted out (e.g., data entry), provide a copy of the contract with the vendor.
93. Describe how the MCO will process and approve out-of-network provider claims, including hospitals, on an ongoing basis (after the 90-day exemption timeframe) and state whether the

MCO will reimburse these providers using the Medicaid fee schedule or an alternate fee schedule.

94. Submit for review the policy on prohibitions of inappropriate physician incentives.
95. Describe the review process for payments for emergency services. Indicate which types of claims are automatically paid, which types are pended, and how pended claims are evaluated for payment. If algorithms are used to evaluate pended claims, describe how the MCO will ensure that the “prudent layperson” standard is upheld.
96. Submit for review MCO policies on reimbursement for crisis stabilization services.
97. Submit for review call transfer protocols and decision trees for the MCO/PBM's provider services hotline.
98. Describe how the MCO educates PCPs on their responsibility to coordinate a member's overall health.
99. Describe the MCO's protocol for conducting outreach to all specialists regarding the importance of encouraging members with complex needs to seek primary care services.
100. Describe how the MCO will educate and provide guidance to PCPs on coordinating physical health services and ensuring that the PCP coordinates the member's medical health services, as appropriate, with behavioral health services.
101. Describe how the MCO will educate PCPs about the importance of dental screenings to ensure appropriate referrals to dental providers. In particular, PCPs should verify that beginning at 6 months after the first tooth erupts or by 12 months of age (as part of the EPSDT process), the member should be referred to dental providers.

102. Describe how providers will be educated about the ability to request out-of-network referrals.

103. Describe the e-Prescribing functions supported.

104. Describe any special provider education efforts that will be used to educate primary and specialty care physicians about foster care beneficiaries and members with complex needs (e.g., opportunities for standing referrals or for specialists to serve as PCPs, availability of case management/disease management). Please provide an overall summary of provider training topics.

V. BENEFIT ADMINISTRATION

105. Describe how the MCO's will impose, monitor and track member copays and quarterly household maximums for medical and pharmacy services.

106. Describe the MCO's Utilization Management (UM) guidelines. Additionally, describe the process for development and revision.

107. Describe how the UM guidelines will generally be applied to authorize or retrospectively review the payments or Medicaid services.

108. Submit training curriculum for WV UM and clinical staff.

109. Describe how UM monitoring activities will operate in conjunction with fraud and abuse detection activities. Describe the MCO's processes for preventing and detecting fraud and abuse related to pharmacy services.

110. Describe how the MCO will modify its standard utilization management protocols when reviewing referral and treatment requests for members with special health care needs (e.g., standing referrals, expedited utilization review processes).

111. Describe any condition-specific protocols or standards that will be used to manage members with special health care needs. Describe how these standards and protocols will be updated and shared with primary and specialty care providers.
112. List the services or types of services that require prior authorization by the MCO, those that can be approved by the member's PCP, and those to which the member can self-refer.
113. Describe the medical services prior authorization (PA) process, including the turnaround time and levels of authority. Provide elements included in the PA approval/denial letters to members and providers. If the behavioral health PA process is different, describe the process.
114. Provide the MCO's required length of time for providers to request prior authorizations for services. If this varies by service or circumstance, provide the applicable length of time for each service/situation.
115. Describe the process to honor medical, behavioral health and pharmacy authorization approvals from previous coverage during the transition period.
116. Describe how providers and/or members will be notified regarding expiration of existing medical and pharmacy authorizations.
117. Describe the process for authorizing out-of-network access, including emergency situations, travel, and medical necessity.
118. Describe the circumstances under which a member might be granted a standing referral to a specialist provider, including the duration and/or number of visits usually granted or maximally allowed. Also indicate the extent to which a specialist provider may:
- Admit patients for inpatient care, choose the hospital of admission, and keep the patient hospitalized;
 - Schedule or provide ancillary services, such as laboratory testing; and

- Refer patients to sub-specialists or other providers.
119. Describe the circumstances in which members might be referred to out-of-network providers and the process for members and/or providers to request out-of-network referrals. Explain the procedures for ensuring that information from non-network providers is shared with the member's PCP.
120. Provide the timeframes for reviewing and processing medical referrals. Describe the average duration of medical referrals.
121. Describe the circumstances and process under which a member may continue an existing relationship with an out-of-network provider (or provider who leaves the MCO's network) if it is considered to be in the best medical interest of the member. Specify how long the MCO will allow members to see out-of-network providers that refuse to contract with the health plan for ongoing courses of treatment past the first 90 days.
122. Separately describe ongoing monitoring of emergency room (ER) usage. Explain application of the prudent layperson standard for all ER visits and if it would not require any prior authorization for screening and stabilization of members.
123. Describe compliance with the post-stabilization care per 42 C.F.R §§438.114(b)&(e) and 42 C.F.R. §422.113(c)(iii).
124. For foster care members, describe the process by which the MCO will work with the prospective member, his or her non-network provider, and the enrollment broker to assist in enrolling and pairing the beneficiary with an appropriate in-network provider within 90 days of enrollment and transferring necessary clinical information to the new provider.
125. Describe Family Planning services.
126. Describe how the MCO will ensure that individuals who have specialists as PCPs are receiving primary care services on an ongoing basis.

127. Describe the mechanisms the MCO will employ to identify pregnant women at enrollment and on an ongoing basis, and the mechanisms that will be used to promote “early and often” prenatal care for women who are identified as being pregnant.
128. Discuss the procedures for identifying individuals with complex or serious medical conditions on an ongoing basis, including to what extent the MCO’s information systems will be used to identify members with special needs and isolate data specific to eligibility category or diagnosis.
129. If crisis stabilization services are subject to medical necessity review criteria, describe how the MCO will ensure timely access to these services and how the MCO will address these types of services that are provided out of network.
130. Describe the procedures and materials that will be used to ensure compliance with EPSDT program requirements, as outlined in the MCO contract. Please provide:
- A plan detailing the specific activities to be performed and responsible staff/departments;
 - Details on how the plan is accomplished in all geographic areas, including copies of all materials developed to inform members, parents, and providers about the EPSDT program; and
 - Sample reports or other tools that will be used to monitor EPSDT services.
131. Describe how the MCO will ensure that children who are receiving primary care from a specialist receive EPSDT services.
132. Provide a general description of how the MCO will manage pharmacy benefits, ensure contractual and regulatory compliance, and coordinate services.
133. Describe the MCO’s approach for creating and updating a non-PDL formulary for drugs not included on the State’s preferred drug list (PDL). Provide related policies and procedures.

134. Describe the MCO's strategy for ensuring compliance with the State's PDL. Provide related policies and procedures.
135. Describe the MCO's process for assisting the State with the rebate resolution process. Provide related policies and procedures.
136. Describe any prescription limits the MCO plans to impose, including limitations on brand name and generic prescriptions. If applicable, provide the policies and procedures for how the limits will be managed and how cases of medical necessity will be handled.
137. Describe any strategies the MCO will use to identify and manage polypharmacy.
138. Describe how the MCO monitors potential abuse or inappropriate utilization of controlled prescription medications and what strategies the MCO may use to manage members with a history of prescription drug abuse (e.g., lock-in). (Note any data that may be needed from BMS to facilitate this transition.)
139. Describe the pharmacy PA process including the turnaround time and levels of authority. Provide elements included in the PA approval/denial letters to members and providers.
140. Submit policies and procedure for authorizing 72h emergency prescription medication supply and reimbursement of supplies.
141. Describe the MCO's process for ensuring that PCPs maintain information shared by behavioral health providers as to the outcome of behavioral health screenings and evaluations (e.g., in a patient's medical record).
142. Describe the MCO's process for informing PCPs on changes in a member's behavioral health status (e.g., hospitalization, emergency room usage, change of medication). Explain what constitutes a change in behavioral health status, and how the MCO will assist members to access additional services as a result of a change in behavioral health status (e.g., care manager can assist in making appointments for members).

143. Describe how the MCO will facilitate coordination of care between PCPs and children's dental providers, especially for children with special health care needs.
144. Describe the MCO's approach for providing dental services for individuals 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.
145. Describe the mechanisms the MCO will use to remind members of upcoming initial and periodic dental screenings as well as the mechanisms to ensure completion of these screenings.
146. Describe MCO arrangements with in- and outpatient facilities for the provision of dental services to members with special needs.
147. Describe any mechanisms the MCO will use to remind members of upcoming initial and periodic dental screenings and ensure completion of these screenings.
148. Describe the MCO's process for monitoring dental screening utilization on an ongoing basis and intervening if a member has not had a screening in over one year.

VI. CARE MANAGEMENT

149. Provide a general overview of the medical, behavioral health, oral health and pharmacy care management programs. Also provide an overview of the management of socially necessary services and the integration of the service types.
150. Describe how the case/care management department is organized (i.e. by disease or problem type).
151. Describe how members are identified for participation in care management programs. Describe at a high level the MCO member screening process and screening timelines upon enrollment.

152. Describe the MCO's protocol for assigning members to an appropriate health care professional who is formally responsible for coordinating the member's overall health care, to include behavioral health and specify whether services are coordinated by the member's primary care provider or through some other means, such as a care manager.
153. Describe any differences in how the MCO will approach adults versus children and any internal processes that may vary between these two groups, including education, member materials, and outreach. Identify any activities or linkages with the WV Children with Special Health Care Needs (Title V) program clinics, providers, or other professionals.
154. Describe identification of and services for members with special needs. Discuss any additional screening or assessment the MCO will perform and what clinical, social, or other criteria the MCO will use to determine which members require case management and assign members to case managers. If the MCO will conduct its own health risk assessment, please provide a copy of the form or protocol.
155. Describe identification of and services for members with behavioral health needs. Discuss any additional screening or assessment the MCO will perform and what clinical, social, or other criteria the MCO will use to determine which members require case management and assign members to case managers. If the MCO will conduct its own health risk assessment, please provide a copy of the form or protocol. Include any additional screening tools utilized in this process.
156. Describe any special member or medical management services, such as health risk assessments or targeted education programs (including those specific to members with special health care needs), that will be made available upon enrollment to members and/or their representatives. What is the MCO's process for identifying who will receive targeted education programs? What is the timeframe for creating education materials and educating the member education and care management staff?
157. Describe the qualifications and training of MCO staff who will be involved in coordinating care. Indicate whether specialized case/care managers will be used for certain conditions (e.g., experienced pediatric or cardiac nurses, behavioral health specialists). If the MCO will hire care management staff, provide the MCO's plan for hiring, including timeframes, number of the CMs, and maximum case load.

158. Describe the MCO's protocol for assigning members to a care manager. Provide the expected timeframe for care manager assignment to the identified member.
159. Describe utilization analysis methods used to identify beneficiaries with special needs or receiving high cost care that would benefit from case management.
160. Describe the steps MCO care managers will take to establish relationships with their assigned members. Based on the member's acuity level, how often do care managers contact members after the initial care management contact on average.
161. Describe how care managers will be monitored and evaluated in regards to establishing relationships with members. Include statistics the MCO will collect and frequency with which they will be collected.
162. Describe the protocol for addressing a member that would benefit from a care manager, but does not want one or cannot be reached once a care manager has been assigned.
163. Describe the process by which the MCO will develop, update, and use clinically appropriate treatment plans that address the coordination of primary, specialty, ancillary, community and social support, and carved-out services for members identified as having special health care needs. How will the MCO identify members in need of such a care plan, and which members will receive care plans. Please provide a sample care plan.
164. Provide the frequency with which care plans will be shared with PCPs and other providers and in what manner (e.g., letter, phone call). Describe who is responsible for sharing care plans with a member's PCP, and what will prompt the MCO to share care plans (i.e., events that occur before the next scheduled date to share the plan with a PCP).
165. Describe which members identified as needing care management receive a treatment plan.
166. Describe how the MCO tracks the completion of care plans.

167. Describe episodic and/or catastrophic case management interventions.
168. Describe the protocol for addressing a provider who does not perform coordination activities. How will this be identified and what action will the MCO take to improve coordination?
169. Describe MCO programs for coordination of care that include coordination of services with community resources and social services in the area served by the MCO. Include: procedures that will be in place for coordination with community resources and social services for members, including those with special health needs; timeframes for identification of such resources and services; and a plan for coordinating community resources and social services for members with special health care needs who have not been assigned to a care manager, but require these services.

VII. QUALITY

170. Describe general administration of the QAPI Program within the MCO. Provide Medicaid and any commercial HEDIS reports from the past two years.
171. Submit a Quality Improvement Plan. At a minimum, it should include the MCO's plans to evaluate how effectively it is delivering quality and accessible services that address the needs of and identify areas of improvement for beneficiaries with special health care needs.
172. Describe the types of data the MCO will use to identify barriers to care for individuals with special health care needs (e.g., focus groups, surveys, "secret shopper calls", aggregate utilization monitoring). How often will quality measures be collected and analyzed?
173. Provide a general description of the MCO's process for developing and updating clinical guidelines, and for disseminating them to participating providers.
174. Describe the MCO's approach for addressing quality issues including what steps will be taken, who is responsible for addressing issues, and the timeframes for resolution.

175. Describe data-driven clinical initiatives that the MCO initiated within the past 24 months that have yielded improvement in clinical care for a managed care population.
176. Describe statistically significant improvements generated by the MCO's clinical initiatives.
177. Provide beneficiary satisfaction measures that will be collected following the "go-live" date. Describe past efforts that the MCO has made to assess member satisfaction.
178. Describe the MCO's practice of profiling the quality of care delivered by network PCPs and any other acute care providers (e.g., high volume specialists, hospitals), including the methodology for determining which and how many providers will be profiled.
179. Describe how the MCO will monitor and reinforce PCP compliance with Medicaid program requirements (e.g., 24-hour coverage, appointment scheduling standards) as outlined in the MCO contract.
180. Describe how the MCO will review complaints and grievances, PCP change requests, out-of-network referrals, emergency room usage, or other data to identify access barriers for members with special needs.
181. Describe how the MCO will use reports/data from the subcontractor to ensure appropriate vendor oversight and beneficiary access/satisfaction/continuity of care.
182. Describe the mechanisms the MCO uses to determine and identify which members have/have not received primary care services (e.g., what types of data and who is responsible for tracking) How frequently will the MCO run this data and how long after identification will the MCO reach out to PCPs and members?
183. Describe any enhancements that will be made to the MCO's ongoing quality monitoring activities to ensure quality for Medicaid beneficiaries and compliance with program requirements (e.g., emergency room utilization, 24-hour PCP coverage, focused clinical studies for West Virginia Medicaid).

DRAFT

LIST OF REQUESTED DOCUMENTS

1. Please provide a copy of each of the documents listed below at the time of application. If multiple documents requested below are contained within a single policy, procedure, or manual, you may submit the whole policy or manual and indicate where each of the components is located within it. All contracts, procedures, and reports must be in compliance with program requirements as outlined in the contract.
 - a) MCO and Subcontractor organizational charts;
 - b) Hiring plan;
 - c) Certificate of Authority from the Office of the Insurance Commissioner and a copy of all materials submitted to the West Virginia Insurance Commissioner;
 - d) MCO Ownership and Control Disclosures;
 - e) Subcontractor monitoring plan;
 - f) Standard provider contracts and disclosure forms (PCPs, specialists (including dentists and behavioral health providers, hospitals, pharmacy));
 - g) Fraud and Abuse Compliance plan;
 - h) Employee False Claims training;
 - i) Advance Directive policies and procedures;
 - j) MCO/PBM/other benefit manager grievance and appeals policies and procedures;
 - k) Provider recruitment plan;
 - l) MCO/PBM/other benefit manager credentialing policies and procedures;
 - m) EOB sample forms;
 - n) Member/Provider Services Department toll-free contact phone numbers;
 - o) Phone call transfer protocols and decisions trees;
 - p) Disenrollment Policies;
 - q) Policy on prohibitions of inappropriate physician incentives;
 - r) MCO policies on reimbursement for crisis stabilization services;
 - s) Medical and Pharmacy Prior Authorization policies, procedures, and a flow-charts;
 - t) Policies and procedures for authorizing 72h emergency prescription medication supply;
 - u) Sample case management plan;
 - v) Quality improvement plan;
 - w) Medicaid and commercial HEDIS reports from past two years.
 - x) Policies and procedures for authorizing socially necessary services

2. Please provide a copy of each of the documents listed below at a later time specified by BMS:
 - a) MCO member handbooks for medical and pharmacy benefits;
 - b) MCO.com website content for WV Medicaid;
 - c) MCO marketing plan;
 - d) MCO grievance and appeals acknowledgement letters and resolution letters;
 - e) MCO/PBM adverse determination letters including Fair Hearing rights;
 - f) Provider Manual (medical, behavioral health, and socially necessary services);
 - g) MCO Provider Directory;
 - h) Sample MCO letters notifying members of the PCP assignment;
 - i) Single MCO member ID card;
 - j) Pharmacy lock-in notification letter;
 - k) Schedule for provider training and webinars during implementation phase;
 - l) Grievance and appeals procedures including the contents and timeframes from notice of action, resolution of grievances and appeals, and how to access continuation benefits.

ATTACHMENT A:
WEST VIRGINIA BUREAU FOR MEDICAL SERVICES
MEDICAID MCO
SAMPLE ON-SITE REVIEW AGENDA

Potential MCOs will participate in an on-site review, approximately two-three days in duration, by BMS to assess the MCO’s readiness to serve Medicaid members and ensure that operations and provider networks are consistent with application documentation prior to contracting. The following is a sample agenda. A final agenda will be developed by BMS after reviewing the application. MCOs should expect to discuss their responses and answer additional follow-up questions during the on-site review.

<p>Introductions</p>
<p>Organization, Staffing, and Management</p> <ul style="list-style-type: none"> • Overview of corporate structure and oversight of WV program • Processes for coordinating work and sharing information among offices • Staffing levels and experience for each major function (for WV line of business) • Use of subcontractors (if any)
<p>Walk-thru of MCO</p>
<p>Enrollment and Member Services</p> <ul style="list-style-type: none"> • Enrollment process and procedures for handling PCP assignment • Organization and training for call center staff • Coordination with Medicaid Administrator/Contract Liaison in WV • Reporting and information sharing • Monitoring and processing of complaints and grievances
<p>EPSDT and Outreach</p> <ul style="list-style-type: none"> • Coordination with enrollment broker • Identification and services for members with special needs • Health promotion and education activities • Prenatal care and EPSDT initiatives, including tracking of appointments, follow-up, etc.
<p>Provider Network</p> <ul style="list-style-type: none"> • Provider contracting update • Monitoring access and availability • Accountability and processes for credentialing
<p>Claims Payment, MIS, and Reporting Capabilities</p> <ul style="list-style-type: none"> • Timely payment standards and experience • Third party liability • Encounter data submission • Overview of information systems and capabilities • Reporting capabilities

Medical Management
<ul style="list-style-type: none">• Overview of utilization management program• Processing of referrals and pre-authorization requirements• Health risk assessment• Case management• Quality assurance program, committees• Approach to monitoring provider performance• Appeal procedures
Document Review
Concluding Meeting

ATTACHMENT B:
WEST VIRGINIA BUREAU FOR MEDICAL SERVICES
PROVIDER NETWORK STANDARDS
SFY20

ATTACHMENT C:
WEST VIRGINIA BUREAU FOR MEDICAL SERVICES
BEHAVIORAL HEALTH NETWORK STANDARDS
SFY20

Draft and Confidential

Please note that all MCO Application and related materials are provided for informational purposes only. Any interested MCO must work with BMS to establish a timeline and receive the most current documents.