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STATE FISCAL YEAR 2022

MODEL PURCHASE OF SERVICE PROVIDER AGREEMENT

BETWEEN

STATE OF WEST VIRGINIA

DEPARTMENT OF HEALTH AND HUMAN RESOURCES

BUREAU FOR MEDICAL SERVICES

AND

(MANAGED CARE ORGANIZATION)

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STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES
PURCHASE OF SERVICE PROVIDER AGREEMENT

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STATE OF WEST VIRGINIA

DEPARTMENT OF HEALTH AND HUMAN RESOURCES

BUREAU FOR MEDICAL SERVICES

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 "BMS," and [Insert Managed Care Organization Name], hereinafter referred to as the "Managed Care Organization (MCO)".

WHEREAS, BMShas conducted an open solicitation for the services of MCOs interested in entering into a Contract to provide risk-based comprehensive health services to West Virginia Medicaid managed care enrollees, 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, BMS has approved the MCO to provide risk-based comprehensive health services to West Virginia Medicaid managed care enrollees,

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

1. GENERAL TERMS AND CONDITIONS

Written MCO responses to a Request for Proposals [BMS2000000002] (hearafter “RFP”) and the Mountain Health Trust (MHT) and West Virginia Health Bridge (WVHB) Medicaid MCO Provider Application, (including BMS’ written responses to oral and written questions, appendices, amendments, and addenda) and/or to other formal requests by BMS 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;

B. MCO responses to the RFP; and

C. Written MCO responses to formal BMS requests for information and documents, including MCO responses, supplemental responses, and clarifications of responses to the MCO Provider Application.

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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 will commence on July 1, 2021 and will be effective through June 30, 2022.

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 (FY).

Using actuarially sound standards, BMS will calculate capitation payments to the MCO on the annual basis for the State Fiscal Year (SFY) time period (i.e., SFY22 begins July 1, 2021, and ends June 30, 2022).

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

3. ENTIRE AGREEMENT

This Contract (including all provisions incorporated by reference in Article I, 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 BMS within the DHHR. The Contracting Officer will be the Director of the Office of Managed Care 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) calendar days after posting if properly addressed and sent certified mail return receipt requested. Notices must be addressed as follows:

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Susan Hall, Director
Office of Managed Care
Bureau for Medical Services
West Virginia Department of Health and Human Resources
350 Capitol Street, Rm 251
Charleston, WV 25301
304-356-4073 (office phone)
Susan.L.Hall@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 to Susan Hall.

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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.

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.

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 MCO to receive out-of-network services; or the denial of an enrollee's request to dispute a finnancial liability, including copayments.

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 BMS to provide assistance with administering its MCO program or any other matter.

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.

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Bureau for Medical Services (BMS) – the West Virginia Bureau for Medical Services within the West Virginia Department of Health and Human Resources, which serves as the Single State Agency in West Virginia for Medicaid. Also referenced in this agreement as "BMS".

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. 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.

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

Choice Counseling – the provision of information and services designed to assist beneficiaries in making enrollment decisions; it includes answering questions and identifying factors to consider when choosing among managed care plans. Choice counseling does not include making recommendations for or against enrollment into a specific 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 a grievance is filed; some complaints may be subject to appeal.

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

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Consumer Assessment of Healthcare Providers and Systems (CAHPS) – a enrollee survey program of AHRQ measure patient experience with health plans, providers, and health care facilities. This survey is conducted annually.

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 or change in a business process that may be required by BMS 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 BMS 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 BMS 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 BMS.

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 BMS through the CMS waiver authority to assign an enrollee who has not selected an MCO to an MCO.

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 & Human Services (DHHS) – the United States 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.

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.

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Durable Medical Equipment (DME) – certain medical equipment or supplies a provider orders for a 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) –Services, including interperiodic and periodic screenings, listed in Section 1905(a) of the Social Security Act. EPSDT entitles Medicaid-eligible infants, children, and and other Medicaid-eligible 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.[1]

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 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.

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[1] Section 1905(r)(5) of the Social Security Act

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

Enrollment Broker – the entity contracted by BMS to conduct outreach and enrollment of eligible West Virginia Medicaid managed care enrollees.

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 BMS 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 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.

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 BMS.

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

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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 or orally , 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.

Healthcare Effectiveness Data and Information Set (HEDIS) – quality measures developed, sponsored and maintained by NCQA. HEDIS is a set of standardized performance measures designed to reliably compare the performance of managed care health plans.

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 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.

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.

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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 BMS' projected financial loss and damage resulting from the MCO's non-performance.

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 all 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 or fee-for-service; 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 BMS, 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 BMS' defined service area within which the MCO has been contracted to provide MCO services.

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Medicaid – the West Virginia Medical Assistance Program operated and funded by BMS 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 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 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 items or services furnished or to be furnished to a patient 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 that are reasonable and necessary for the diagnosis or treatment of illness or injury; to improve the functioning of a malformed body member; to attain, maintain, or regain functional capacity; for the prevention of illness; or to achieve age-appropriate growth and development. Determination of medical necessity is based on specific criteria.

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.

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.

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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 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.

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 enrollee 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).

Premium – an amount enrollees would pay for Medicaid health insurance every month in addition to any co-payments required for covered services or supplies.

Prescription Drug Coverage – health insurance that helps pay for prescription drugs and medications. Prescription drug coverage is not provided by the MCO. BMS 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.

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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 a enrollee of 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.

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 Proposal (RFP) – a document, containing the specifications or scope of work and all contractual terms and conditions, which is used to solicit written bids.

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 BMS.

Risk Adjustment – a methodology applied to the rate setting process to account for the health status of enrollees via relative risk factors when predicting or explaining costs of services covered under the contract for defined populations or for evaluating retrospectively the experience of MCOs contracted with the State. Risk adjustment uses information on an enrollee's medical conditions, as reported in claims data, to predict health care costs and adjust payments to MCOs. Risk adjustment helps ensure payments to MCOs are more equitable and mitigates the impact of selection bias, thus protecting MCO solvency and reducing incentives for plans to avoid high-risk individuals. Risk adjustment is designed to be budget neutral to the State.

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.

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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 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.

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.

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.

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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).

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

West Virginia's BMS within DHHR is the single state agency responsible for administering the Medicaid program. 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

BMS will determine the initial and ongoing eligibility for medical assistance of each enrollee or potential enrollee under this Contract.

4.2 Enrollment

BMS will conduct MCO enrollment process in accordance with 42 CFR §438.54. BMS, either directly or through its designee, will process all enrollments into the MCO. BMS will notify the

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MCO of such enrollments by means of a 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 or electronic media, and will be delivered by BMS 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 Default Enrollee Assignment

BMS, either directly or through its designee, will use default assignment methodology to enroll individuals who do not select an MCO. To the extent possible, BMS will make assignments based on an enrollee's prior history with the MCO and pre-established familial relationship, with an equitable number of the entire default membership assigned to each MCO by the end of a monthly default assignment process.

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. BMS 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 another MCO, or other causes).

BMS has federal authority to implement an enrollment lock in policy in which enrollees are locked-in to a single MCO for a twelve (12) month period though may request to change their MCO enrollment in accordance with 42 CFR §438.56. Should BMS implement this policy during the Contract year, the MCO will be required to supply all necessary information requested by the enrollment broker regarding BMS' enrollee lock-in program.

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 that have completed the enrollment process through the Department's Enrollment Broker.

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.

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In full consideration of Contract services rendered by the MCO, BMS agrees to pay the MCO monthly payments. BMS capitation payments to the MCO will apply to the time period July 1, 2021, through June 30, 2022 (State Fiscal Year 2022). 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 BMS.

Except for emergency services, 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.

Payments 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.

BMS 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. BMS 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 program participation. The MCO will be paid a capitated rate on a per member per month (PMPM) basis [2], 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. Payment will be based on actual monthly participation. The final payment will be made upon determination by BMS that all contractual requirements have been completed.

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, BMS 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 BMS and were incurred by the MCO. Any such expenses and/or costs would then be deemed unallowable by BMS. If BMS retroactively recoups money from the MCO due to a federal disallowance, BMS will recoup the entire amount paid to the MCO for the federally disallowed expenses and/or costs, not just the federal portion.

Should any part of the scope of work under this contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the MCO must do no work on that part after the effective date of the loss of program authority. The state must adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. If the MCO works on a program or activity no longer authorized by law after

[2] Enrollees will only be enrolled on the first of the month and must stay with the MCO until the 30th before changing MCO's.

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the date the legal authority for the work ends, the MCO will not be paid for that work. If the state paid the MCO in advance to work on a no-longer-authorized program or activity and under the terms of this contract the work was to be performed after the date the legal authority ended, the payment for that work must be returned to the state. However, if the MCO worked on a program or activity prior to the date legal authority ended for that program or activity, and the state included the cost of performing that work in its payments to the MCO, the MCO may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

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 Medicaid 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. BMS will make every effort to ensure that only those Medicaid enrollees eligible for managed care enrollment are enrolled in the MCO.

In instances where enrollment is disputed between two (2) MCOs, BMS 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 BMS of an enrollee's request to disenroll, when such requests are submitted to the MCO.

4.8 Enrollee Reinstatement Processing

Medicaid enrollees who lose eligibility for the West Virginia MHT or WVHB programs and regain eligibility within one (1) year will be automatically re-enrolled in the same MCO in which they were previously enrolled, unless the enrollee chooses another MCO. BMS will perform this process and supply the necessary information to the enrollment broker. If a previously eligible recipient has been ineligible for a period of time in excess of one (1) year, the enrollee will select a MCO through the standard enrollment broker enrollment process.

BMS will notify the MCO in writing of any exclusion initiated by DHHR for a fee-for-service (FFS) Medicaid 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, BMS will undertake the following monitoring activities 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.

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3. Review MCO certifications on a regular basis.
4. At its 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 participation are excluded from the MCO Medicaid provider network.

These monitoring activities will take place at least once per year. BMS or its contractors must provide to the MCO summaries, at BMS' expense, of all monitoring activity reports, surveys, audits, studies, reviews, and analyses.

4.10 Utilization Review and Control

In accordance with 42 CFR §438.210(a)(4), the MCO may place appropriate limits on the covered services provided under this Contract on the basis of criteria applied under the Medicaid State Plan, such as medical necessity or for the purpose of utilization control, provided that:

1. MCO services can reasonably be expected to achieve the purpose for which such services are furnished;
2. Services supporting individuals with ongoing or chronic conditions are authorized in a manner that reflects the enrollee's ongoing need for such services and supports; and
3. Family planning services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used.

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 the respective federal regulations.

BMS will have the authority to override any MCO utilization management guideline on a case-by-case basis. The BMS Medical Director shall 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.

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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 BMS. 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 BMS within the timeframes outlined in this Contract or in the BMS' request, BMS 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 day an item is overdue beyond the grace period, BMS 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).

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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, BMS will have the right to terminate this Contract with thirty (30) 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 BMS, 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 Enrollment Broker and 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); and Title 45, Parts 160 and 164, 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 BMS, 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.

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

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 4 of the contract.

5.10 Key Staff Positions

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

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

Key Staff	
Chief Executive Officer/Chief Operating Officer (CEO/COO)*	Chief Financial Officer*
	Compliance Officer
Contract Liaison/MHT Administrator	Medical Director
Medical Management Director	Care Management Director
Behavioral Health Medical Director	Quality Director
Member Services Director	Claims Payment Director
Network Development Director	Provider Relations Director
Program Integrity Lead	Information Technology Director
Community Engagement Director	Encounter Data Integrity Manager
MHT Member Advocate	Dental Director

*The CEO/COO and CFO positions are not required to be Medicaid-only positions.

The MCO must notify BMS in writing of changes in key staff positions when individuals either leave or fill these key positions within ten (10) calendar days of any change. The MCO must also provide an updated organizational chart within ten (10) calendar days of request.

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The Medical Director and the Director of Medical Management, or designee must respond to requests of the BMS' Medical Director or Contract Administrator within three (3) business days.

5.10.1 Key Staff Requirements

The MCO's Key Staff must also meet the following requirements, as applicable:

1. The Chief Executive Officer/Chief Operating Officer (CEO/COO) shall serve in a full time (40 hours per week) position available during BMS business hours to fulfill the responsibilities of the position and to oversee the entire operation of the MCO. The CEO/COO shall devote sufficient time to the MCO's operations to ensure adherence to program requirements and timely responses to BMS. The CEO/COO shall be authorized and empowered to make contractual, operational, and financial decisions for the contract, related to business, claims payment, provider relations/contracting, and all other functions of the MCO. The CEO/COO must be directly employed by the MCO. The CEO/COO must attend in person, upon BMS request, meetings, and hearings of legislative committees, interested governmental bodies, agencies, and officers. The CEO/COO must establish and maintain positive client relationships, make contractual, operational, and financial decisions on behalf of the MCO, and oversee and provider overarching contract oversight for the MCO. The CEO/COO must have at least ten (10) years' experience in Medicaid managed care oversight and operations, ten (10) years' experience in healthcare administration and operations, a bachelor's degree or higher and be based in West Virginia.
2. The Contract Liaison/MHT Administrator is responsible for overall delivery of the project, serving as a liaison with BMS during all phases of the contract. The Administrator must attend in person, upon BMS request, meeting and hearings of legislative committees and interested governmental bodies, agencies, and officers. The Administrator must maintain a positive client relationship, provide timely and informed responses to operational and administrative inquires that arise, meet with BMS staff or such other persons as designated by BMS on a regular basis to provide oral and written status reports and other information as required. The Administrator must respond to issues involving information systems and reporting, appeals, quality improvement, member services, service management, pharmacy management, medical management, and care coordination. The Administrator must ensure that each member has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the member, per 42 CFR §438.208(b)(1). The Administrator must have at least five (5) years' experience in Medicaid managed care contract oversight and five (5) years' experience in healthcare, experience working with low-income populations, and cultural sensitivity, a bachelor's degree or higher and be based in West Virginia
3. The Chief Financial Officer (CFO) is responsible for oversight of all financial activities of the project. The CFO must oversee the MCO's provider payment arrangements, including Alternative Payment Models (APMs), sign data certification forms, including, at a minimum, all encounter data and financial data and reporting for payments to contracted providers, and certified payment information to be utilized for rate-setting purposes or any payment-related data required by the Department. The CFO must have at

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least five (5) years' experience serving as a financial lead for a managed care entity or other health insurance provider and a bachelor's degree or higher.

4. The Compliance Officer is responsible for all compliance-related activities, including developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of this contract, and State and federal regulations. The Compliance Officer shall report directly to the CEO/COO and will serve as the primary contact person for all BMS MHT compliance requests and concerns. The Compliance Officer must have at least five (5) years' experience serving as a compliance officer or lead in the healthcare industry for a Medicaid managed care or other healthcare entity, a bachelor's degree or higher and be based in West Virginia
5. The Medical Director, who is a physician with a current, unburdened license through the West Virginia State Medical Board, shall have at least three years of training in a medical specialty. The Medical Director shall devote full time (a minimum of 32 hours per week) to the MCO's operations to ensure timely medical decisions, including after-hours consultation as needed. The Medical Director shall be actively involved in all major clinical and quality management components of the MCO. The Medical Director must have at least five (5) years' experience in serving as Medical Director for a Medicaid program and five (5) years' experience working in pediatric care, an active West Virginia Medical License and be based in West Virginia.
6. Medical Management Director is responsible for oversight of utilization management activities of the project, including oversight and management of processing referrals and pre-authorization requirements, as well as familiarity with appeals procedures. The Director must respond to requests from the BMS's Medical Director or Contract Administrator within three (3) business days. The Director must have at least five (5) years' experience working as a utilization management manager or specialist for a Medicaid program, be a registered nurse (RN) or Licensed Clinical Social Worker (LCSW) in West Virginia and be based in West Virginia.
7. The Care Management (CM) Director shall be responsible for overseeing the day-to-day operational activities of the Care Management Program in accordance with state guidelines. The CM Director is responsible for ensuring the functioning of care management activities across the continuum of care (assessing, planning, implementing, coordinating, monitoring, and evaluating). The CM Director shall have experience in the activities of care management as specified in 42 CFR §438.208. The Director must have at least five (5) years' experience working as a case manager or care coordinator for a Medicaid program, be a West Virginia licensed registered nurse or a West Virginia licensed independent social worker with a demonstrated ability to community with members who have complex medical needs and may have communication barriers. The Director must be based in West Virginia.
8. The Behavioral Health (BH) Medical Director must employ or contract with an independent, active, and unrestricted West Virginia medical license in a related behavioral health specialty. The BH Medical Director must have at least five (5) years' experience in serving as BH Lead or expert for a Medicaid program and five (5) years' experience working in BH clinical care, including substance use. The BH Medical Director shall demonstrate knowledge of West Virginia's overall BH system which

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includes mental health, alcohol and drug addiction, and developmental disabilities services. He or she shall be responsible for the daily operational activities of BH services across the full spectrum of care to members, inclusive of mental health and substance use services.

9. The Quality Director shall be responsible for oversight of the quality assurance program and related activities. The Director develops, administers, and oversees the QAPI program, oversees and supports accreditation activities, and oversees and participates in the QAPI Committee. The Director initiates and maintains quality improvement projects that focus on one or more quality indicators, develops an approach to monitor provider performance, in collaboration with Network and Provider Relations staff, and engages in activities related to APMs as they related to quality of care measures and performance indicators. The Director must have at least five (5) years' experience in overseeing a Medicaid quality program, either with an MCO, a state Medicaid agency or an external quality review organization, a bachelor's degree or higher and be based in West Virginia.
10. The Member Services Director is responsible for oversight of activities related to call center operations, enrollment and disenrollment activities, grievances, and other member-related inquiries and matters. The Director oversees the Member Services Department to assist members in obtaining covered services, interfaces with members and providers to handle questions and complaints, ensures that the member services phone line meets the minimum performance requirements and oversees the enrollment and onboarding activities of members. The Director must have at least three (3) years' experience working with the public in an educational capacity on health insurance-related matters and experience working in or overseeing a call center. The Director must have a bachelor's degree or higher and be based in West Virginia.
11. The Claims Payment Director is responsible for oversight of all physical and behavioral health claims payment- and encounter-related activities. The Director shall ensure timely and accurate payment of provider claims for physical and behavioral health services, and in general monitors claims processing activities for these services and oversees the reprocessing of claims due to rate changes or claims resubmissions. The Director must have at least three (3) years' experience in claims processing and encounters with a health insurer, a bachelor's degree or higher and is based in West Virginia.
12. The Network Development Director is responsible for network development and contracting activities for physical and behavioral health services. The Director establishes and maintains the provider network in geographically accessible locations for the population and ensures sufficient provider contracts for physical and behavioral health services to maintain access to care in accordance with BMS's Medicaid managed care network requires. The Director facilitates physical health and behavioral health provider contracting activities, including creative payment arrangements and APMs, oversees physical health and behavioral health provider contracting documents and addenda and supports the oversight of physical health and behavioral health provider credentialing activities. The Director must have at least five (5) years' experience serving as a network manager in a health insurance role, a bachelor's degree or higher, and be based in West Virginia.

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13. The Provider Relations Director is responsible for interfacing with the provider community and supports ongoing provider relationships. The Director monitors and respond to provider inquiries, complaints and communications and develops training for contracted provider and their staff in relation to the requirements of this contract and the special needs of the population. The Director designs, develops and implements an annual provider satisfaction survey and ensures the development, distribution, and maintenance of a provider manual. The Director must have at least three (3) years' experience in serving as a provider relations manager or specialist in a health insurance role, a bachelor's degree or higher and be based in West Virginia.
14. The Program Integrity Lead is responsible for all compliance-, program integrity-, and fraud-related activities. The Lead creates internal controls, policies, and procedures to prevent and detect fraud and abuse. The Lead establishes and maintains an SIU to investigate possible acts of fraud, waste and abuse for all services provided under this contract, serves as the primary contact person for all BMS and WVCHIP Program Integrity and Medicaid Fraud Control Unit (MFCU) record requests and monitors provider fraud for underutilization of services and member/provider fraud for overutilization of services. The Lead must have at least three (3) years' experience working on Medicaid fraud projects, a bachelor's degree or higher and be based in West Virginia.
15. The Information Technology Director is responsible for all systems, data, and hardware activities. The Director is required to submit reports, requests for information, documentation, ad hoc reports, data certification forms, or any other data required as requested by the BMS within the time frames provided in this contract. The Director must maintain reasonable safeguards against the destruction, loss, or alteration of any data in the MCO's possession, manage system configuration, testing and implementation activities, maintains a health information system that collects, integrates, analyze, and repots necessary data for reporting purposes and oversees all systems-related activities, including the MCO's EHR, claims processing system, provider data system, etc.. The Director must have at least three (3) years' experience working in Medicaid IT solutions, with an emphasis in data integrity and at least a bachelor's degree or higher.
16. The Community Engagement Director is responsible for marketing, public relations, and community engagement activities. The Director must develop and maintain Medicaid marketing policies and procedures in adherence to state and federal regulations, develops and submits all marketing materials to BMS, develops a written marketing plan, ensures prohibited marketing activities do not occur and engages with the community and providers educational and informational materials at outreach events, in accordance with marketing activity guidelines. The Director must have at least three (3) years' experience in working with the general public to better understand the healthcare environment and insurance, preferably with familiarity with West Virginia and its population characteristics. The Director must have a bachelor's degree or higher and be based in West Virginia.
17. The Encounter Data Integrity Manager is responsible for oversight of all physical and behavioral health claims payment- and encounter-related activities. The Encounter Data Integrity Manager must be available to meet in-person with BMS staff or designees to provide oral and written status reports and other information as required. The Manager

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must ensure timely, accurate, and complete reporting of all encounter data submissions, including subcontractor data, oversee the resubmission of encounter data due to identified claim adjustments due to rate changes or claims resubmission and oversee the submission and data integrity of encounter data. The Manager must have at least three (3) years' experience in encounters and data integrity activities with a health insurer and a bachelor's degree or higher.

18. The MHT Member Advocate is responsible for interacting with the member population, and ensures members are referred to and connected to appropriate resources. The MHT Member Advocate must collaborate with the Care Management Director and care coordinators, provide member support related to enrollment, access and continuity of care issues, support members throughout any grievances or appeals activities, assist members in obtaining materials in alternative formats and interact with members in a culturally sensitive manner. The MHT Member Advocate must have at least five (5) years' experience in healthcare, working with low income populations, a bachelor's degree or higher and be based in West Virginia.
19. The Dental Director is responsible for the oversight of the administration of dental services within this contract. The Director 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. The Director must have at least five (5) years' experience in serving as a dental manager or director for a Medicaid program and must be a qualified dentist licensed in the State of West Virginia.

5.11 Location of Operations

The MCO must notify BMS 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.

5.12 Communication with BMS

The MCO must acknowledge receipt of BMS' 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 BMS. The MCO's information request acknowledgment must include a planned date of information request resolution. A detailed resolution summary advising BMS of the MCO's action and resolution must be rendered to BMS in the format requested.

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

MCO's failure to communicate complete, meaningful, and timely responses to all BMS' 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.

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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:

- 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, 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;
- Health Care and Education Reconciliation Act of 2010 (HCERA); and

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- 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 Patient Protection and Affordable Care Act (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.

The MCO must fully comply with W. Va. Code §11-27-10a which imposes a tiered tax on a PMPM basis on all entities holding a health maintenance organization certificate of authority in the State of West Virginia.

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,

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conditions of or type of enrollment in the geographic areas within the managed care initiative, or need for health care services.

BMS 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 recipients 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 BMS.

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 BMS a disclosure form as provided in 45 CFR §93.110 to 45 CFR Part 93, 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.

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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 BMS.

5.19 BMS' Data Files

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

BMS' data will not be utilized by the MCO for any purpose other than that of rendering services to BMS under this contract, nor will BMS' 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 BMS approval.

BMS 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 BMS' 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 BMS.

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 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.

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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, 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 BMS' objectives and standards, as set forth in the Contract. All areas of responsibility and all Contract requirements will be subject to performance evaluation by BMS. A designated representative of the MCO and a designated representative of BMS 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 BMS for information, assistance, or support within the timeframe specified by BMS.

Non-performance of this Contract includes, but 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 BMS, 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 enrollee, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by enrollees whose medical condition or history indicates probable need for substantial future medical services;
- Misrepresenting or falsifying information that the MCO furnishes to CMS or to the State;

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- Misrepresenting or falsifying of information that the MCO furnishes to an enrollee, potential enrollee, or health care 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, BMS may require the MCO to submit to BMS or its designee a written plan (the "Corrective Action Plan (CAP)") to correct or resolve non-performance of the Contract, as determined by BMS.

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. BMS may require a CAP to provide:
    a. Accelerated monitoring that includes more frequent or more extensive monitoring by BMS 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 BMS' request for a CAP. The CAP is subject to approval by BMS, which will not be unreasonably withheld.
4. BMS will notify the MCO in writing of its final disposition of BMS' concerns. If BMS accepts the MCO's proposed CAP, BMS may:
    a. Condition such approval on completion of tasks in the order or priority that BMS 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.

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5. BMS' 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 BMS from assessing additional Contract remedies or pursuing other appropriate remedies for continued non-performance.

BMS 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 BMS from exercising that authority.

6.3 Conditions Endangering Performance

At its option, BMS 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 BMS) to be provided 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 BMS, 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.

BMS must notify the CMS Regional Office at any time any of the above conditions are found to exist or 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

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- 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, BMS, 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, BMS 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 BMS may pursue contractual remedies for non-performance under the Contract. At any time and at its discretion, BMS may impose or pursue one (1) or more remedies for each item of non-performance and will determine remedies on a case-by-case basis.

BMS 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 BMS 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, BMS will impose, in writing, Liquidated Damages against the MCO. BMS will assess Liquidated Damages against the MCO regardless of whether the non-performance is the fault of the MCO or the MCO's Subcontractors, agents and/or consultants, provided BMS has not materially caused or contributed to the non-performance.

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 BMS' 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, BMS 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 BMS 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. BMS 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 BMS imposes Liquidated Damages on the MCO for charging premiums or charges in excess of the amounts permitted under the Contract, BMS will deduct the amount of the overcharge from the Liquidated Damage and return it to the affected enrollee.

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If at any time BMS determines the MCO has not met any aspect of the responsibilities of the Contract and/or the specific performance standards due to mitigating circumstances, BMS reserves the right to waive all or part of the Liquidated Damages.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 enroll that entity's enrollees in other MCOs or provide their Medicaid benefits through other options included in the State Plan.

Nothing precludes BMS' 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, BMS 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 BMS. BMS 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 BMS' 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 BMS determines non-performance by the MCO under this Contract, BMS may suspend enrollment including default assignment of new enrollees into the MCO under this Contract. BMS, when exercising this option, must notify the MCO in writing of its intent to suspend new enrollment or default assignment 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 BMS, 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. BMS 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.

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6.7 Payment Suspension

BMS may suspend portions of capitation payments from the MCO as a remedy for non-performance. Whenever BMS determines that the MCO has failed to provide one (1) or more of the Medically Necessary covered Contract services, BMS 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 BMS expected the MCO to pay for Medically Necessary covered Contract services, plus any administrative costs involved. The MCO may not deny any Medically Necessary 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, BMS must submit to the MCO a list of the enrollees for whom payment is being suspended, the nature of service(s) denied, and payments BMS must make to provide Medically Necessary covered Contract services. When all payments have been made by BMS for the MCO Medically Necessary covered Contract services, BMS will reconcile the estimated suspension against actual enrollee payments.

BMS 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 BMS 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 BMS 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, BMS. The Commissioner, BMS 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, BMS 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 BMS within sixty (60) calendar days of the end of the hearing. The MCO and/or BMS 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, Department of Health and Human Resources 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

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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.

BMS 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 BMS 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 BMS toward Contract performance within a period of thirty (30) calendar days after receipt of notice of default (or such longer period as BMS 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 BMS 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 BMS 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 BMS may allow.

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

1. Suspension of enrollment;

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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.

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 BMS, 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 BMS 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, BMS 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 a ninety (90) day written notification to the State of West Virginia, Department of Administration Purchasing through BMS, whenever BMS 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 BMS 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 BMS terminates the Contract for default, the MCO will be responsible for all reasonable costs incurred by BMS, 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

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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 BMS or may terminate this Contract at any time with at least a thirty (30) calendar day written notice. The MCO must provide BMS a ninety (90) day notice to terminate the Contract. 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 BMS.
2. At a price mutually agreed to by the MCO and BMS 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 by BMS of at least thirty (30) calendar days prior to termination or by the MCO of at least ninety (90) calendar days prior to the 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 BMS 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 BMS 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 or for the Medicaid 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 BMS 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, BMS 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.

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If BMS is not allotted funds in any succeeding fiscal year for the continued use of the services covered by this contract, BMS 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. BMS is obligated to pay all charges incurred through the end of the then fiscal year at which time this Contract will terminate. BMS must give the MCO written notice of such non-allocation of funds as soon as possible after BMS receives notice of such non-allocation. No penalty may accrue to the in the event this provision is exercised.

6.14 Termination Obligations of Contracting Parties

Upon Contract termination, the MCO and Subcontractors must allow BMS, 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 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 BMS and to newborns born to enrolled mothers during the remaining Contract period. The MCO must provide BMS with the names, PCP assignments, and primary diagnosis of all enrollees with care needs that require WVDHHS 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 BMS, with weekly updates thereafter. The MCO must provide BMS with the names and treatment plans of enrollees with such plans.

Upon Contract termination, the MCO and Subcontractors must provide BMS 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. BMS 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:

- BMS 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:

- BMS will be responsible for notifying all enrollees of the date of termination and process by which the enrollees will continue to receive services; and
- BMS 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 BMS 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

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deliverables, in whole or in part, that BMS 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 BMS or a subsequent contractor. BMS or subsequent contractor must receive and verify all relevant data, documentation, and information. If BMS determines that the data, documentation, or information is not accurate, complete, or HIPAA-compliant, BMS reserves the right to hire an independent contractor to assist BMS 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 BMS 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. BMS reserves the right to review the MCO Transition Plan and any significant modifications to the previously approved Transition Plans. BMS reserves the right to provide CMS with Transition Plan documentation upon request.

The MCO must transfer to BMS 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 BMS or a subsequent contractor:

- The MCO must provide data, information, and services necessary and sufficient to enable BMS to map all MCO data from the MCO's system(s) to the replacement system(s) of BMS or a successor contractor, including a comprehensive data dictionary as defined by BMS.
- The MCO must provide all necessary data, information, and services in the format defined by BMS, 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 BMS and according to the schedule approved by BMS in the Transition Plan.
- If the MCO does not provide the required data, information, documentation or services necessary for BMS or the subsequent contractor to assume the operational activities successfully, the MCO must reimburse BMS 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 BMS' ability to impose remedies as set forth in the Contract.

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6.16 Cooperation with Other Contractors and Prospective Contractors

The MCO must cooperate with other BMS 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 BMS 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

BMS 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 provided by BMS prior to the MCO or its Subcontractor(s) operational start date(s). BMS 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 BMS or its designated agent may occur if:

1. A new MCO is contracted by BMS;
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 BMS or CMS.

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

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8. OTHER REQUIREMENTS

8.1 Inspection of Facilities

The MCO and its Subcontractors must provide the State of West Virginia, CMS, the Office of the Inspector General and any other legally authorized governmental entity or their authorized representatives, the right to enter 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, the Office of the Inspector General, the Comptroller General, their designees, and any other legally authorized governmental entity may conduct such inspections and record/documentation audits 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). BMS 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 BMS 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 BMS.

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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 Medicaid managed care program services and expenditures, including reports to BMS 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 BMS 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 BMS 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). 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 BMS.

The Secretary, DHHS and BMS or a designee 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 BMS or to a designee of BMS all records, books, documents, papers and files that are related to persons receiving services and to the administration of this Contract that BMS may request.

The MCO must provide, and cause its Subcontractors to provide, BMS 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. BMS 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 BMS' 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

BMS 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 designees, 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 (10) years from the completion date of this Contract as extended, or from the date of completion of any audit, whichever is later. 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

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verify the cost of services rendered under this Contract. The MCO and its Subcontractors agree that authorized State representatives including, but not limited to, BMS 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 year post-Contract period, or until final resolution of all pending audit questions and litigation. During the Contract period, access to these items will be provided to BMS 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 (10) year post-Contract 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 the statutory basis of accounting.

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 BMS 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, must be retained for at least ten (10) years from the date of expiration or until 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 completion of the action and resolution of all issues which arise from it, or until the end of the regular ten (10) 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 (10) years and must have written policies and procedures for storing this information. The record retention policy is for all documentation, including but not limited to, enrollee grievance and appeal records in 42 CFR §438.416, base data in 42 CFR §438.5(c), MLR reports in 42 CFR §438.8(k), and the data, information and documentation specified in 42 CFR §438.604, §438.606, §438.608, and §438.610. The State, CMS, the OIG, the Comptroller General and their designees have the right to audit records or documentations of the MCO for the ten (10) year period from the final date of the contract period or from the completion of any audit, whichever is later.

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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 BMS 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 State, CMS, the OIG, the Comptroller General, and their designees or its authorized agents to examine the Subcontractor agreement and all related records, including the ability to inspect and audit any records or documents.

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. BMS 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 BMS 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 BMS. This provision includes reassignment of the Contract due to change in ownership of the MCO. BMS 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.

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

BMS 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).

The MCO must submit a report listing each Subcontract, Subcontractor name, Subcontract effective dates and functions by July 1st of every year to BMS.

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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 BMS with a written notification no later than three (3) business days if a serious breach of a Subcontract occurs.

The MCO must provide BMS 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 BMS 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 BMS 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 BMS. 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. BMS 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 must 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

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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 BMS 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 BMS 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 BMS;
3. When the state renews or extends the MCO contract;

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4. Within thirty-five (35) calendar days after any change in ownership of the MCO; and
5. Within thirty-five (35) calendar days of BMS request.

The MCO must also submit to BMS 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 BMS 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 BMS, the MCO must submit information on any person who is a director, officer, principal, partner, agent, managing

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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 BMS finds that the MCO is not in compliance with this provision, BMS: (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 BMS 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 or BMS: 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 BMS 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 the Bureau. All other legal proceedings, actions, and events may be requested at the Bureau’s discretion, but are not required to be reported upon awareness of occurrence.

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9. SIGNATURES

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

West Virginia Department of Health and Human Resources, Bureau For Medical Services

Signature: _____

Printed Name: _____

Title: _____

Date: _____

State of West Virginia, Department of Administration Purchasing Division

Signature: _____

Printed Name: _____

Title: _____

Date: _____

Managed Care Organization

Signature: DocuSigned by: 471124B160224EC... _____

Printed Name: Jeff Knight _____

Title: President and COO _____

Date: April 19, 2021 _____

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ARTICLE III: STATEMENT OF WORK

1. COVERED SERVICES

1.1 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 services which the MCO is required to provide, as well as those which are excluded; however, the Medicaid policy is the final source for defining these services. 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.

The MCO must promptly provide or arrange to make available for enrollees all Medically Necessary services listed in Contract Appendix A and assume financial responsibility for the provision of these services. The MCO is responsible for determining whether services are Medically 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, licensed practical nurses, and registered nurses. The MCO is also responsible for providing emergency transportation as outlined in Article III, Section 1.2.2 and in Appendix A.

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

"Medically Necessary" is defined as a determination that items or services furnished or to be furnished to a patient are reasonable and necessary for the diagnosis or treatment of illness or injury, to improve the functioning of a malformed body member, to attain, maintain or regain functional capacity, for the prevention of illness, or to achieve age-appropriate growth and development.

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 capitation rate PMPM and will not be permitted to collect any additional copayments or premiums from enrollees. Contract Appendix B (Overview of West Virginia's SFY21 MHT and WVHB Payment Methodology and Capitation Rates) contains a listing of the current capitation rates.

For future year Contract renewal periods, the amount bid for each population cohort shall remain the same unless falling outside of the actuarially developed rate range for the new fiscal year. BMS must obtain documentation of acceptance of updated actuarially developed rate from the MCO.

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

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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-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 BMS and the MCO (in which case an appropriate adjustment to the payment rates would be made).

1.2 Additional Requirements/Provisions for Certain Services

1.2.1 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 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit provided for Medicaid eligible children under the age of twenty-one (21). EPSDT services include all mandatory and optional Medically Necessary services (including treatment) and items listed in 42 USC 1396d(a) to correct or ameliorate defects, and physical and mental illness and conditions discovered by the HealthCheck screening. EPSDT services are included in the prepaid benefit package for children and adolescents up to age twenty-one (21). The federal government, through the Centers for Medicare and Medicaid Services (CMS), requires states to demonstrate an eighty percent (80%) compliance rate for EPSDT screening schedules.
MCOs are required to:

1. Provide annual notification to the parents, or custodian of the child, of screening due dates;
2. Provide outreach and education to providers, parents, and custodians on the importance of completing EPSDT screenings using HealthCheck screening questions and/or protocols;
3. Perform the screenings according to the State-determined periodicity schedule according to the age of the child;
4. Make the necessary and appropriate referrals for corrective treatment as determined by child health screenings immediately, with follow-up contact to ensure the enrollee receives a complete, appropriate evaluation;
5. Track referrals and treatments to:
    a. Ensure screening are completed for enrollees; and
    b. Ensure that enrollees with identified needs through the screening are linked to Medically Necessary services.
6. Record the results in the child’s record and report to the State via the encounter reporting system; and
7. Report results as necessary to meet federal requirements, as requested by BMS.

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MCOs must have written policies and procedures describing the MCO's responsibility 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 and accessible for the hearing- and visually impaired. Translation services must be made available as necessary. The full scope of EPSDT service requirements is described below.

MCOs must, at a minimum, use the HealthCheck screening questions and will encourage and educate contracted providers to use the HealthCheck screening forms and/or protocols. MCOs must also outreach to parents to encourage consistent participation in the EPSDT screenings and benefits. MCOs must ensure that providers answer the questions contained on the HealthCheck forms regardless of how their actual materials are formatted, so that such information can be recorded and reported to BMS with any other information required for the purposes of tracking EPSDT participation goals.

Based on BMS' CMS-416 MCO report, if BMS' overall rate falls below eighty percent (80%), BMS reserves the right to require the MCOs to implement a PIP to improve the rate. MCOs shall implement the PIP required by BMS within 90 days.

1.2.1.1 Provide Information on EPSDT 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 (or their families) about the EPSDT program. MCOs must have an established process for ensuring all reminders, follow-ups, and outreach to EPSDT service enrollees are accessible and culturally competent for all enrollee populations.

The MCO must provide all EPSDT eligible individuals (or their families) with accurate, current information about the EPSDT program using clear and non-technical language. The MCO must inform each new enrollee under the age of 21 about HealthCheck services as specified by 42 CFR §441.56 within five (5) calendar days of receipt of the monthly enrollment file. The MCO may meet this requirement by including information with the new enrollee materials as specified in 42 CFR §441.56 that 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 list of the intervals at which enrollees under the age of 21 should receive screening examinations, as indicated by the most recent version of the West Virginia Periodicity Schedule which aligns with the guidance published by Bright Futures/American Academy of Pediatrics;
4. A statement that the services provided under the EPSDT program are without cost to eligible individuals under twenty-one (21) years of age; and
5. A statement that necessary transportation and scheduling assistance is available to the EPSDT eligible individual upon request (non-emergency transportation is paid by BMS outside of the MCO capitation system).

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1.2.1.2 Perform the 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 the Department for Health and Human Resources, and corresponds to the American Academy of Pediatrics' (AAP) 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, these 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 that should be supervised;
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.

1.2.1.3 Make the Necessary Referrals

In addition to any diagnostic and treatment services included in the defined benefit package, the MCO must provide the following services to eligible EPSDT 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;
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); and

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4. Medically Necessary specialized treatment and/or behavioral health services.

If a suspected problem is detected during a 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 covered 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 must also connect the enrollee and their family to their local community health and human service agencies either via a care manager or referral for additional resources and support to manage uncovered treatments.

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.

1.2.1.4 Track 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 governance of the Bureau for Public Health, the periodicity of preventive pediatric visits must follow the 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 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 no more than six (6) months after the screening services.
4. Behavioral health, dental, and any other screenings performed for enrollees.

1.2.1.5 Report the Results

BMS 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.

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The MCO must maintain data for medical, behavioral, and dental screenings in a standardized format to the extent feasible and appropriate. The MCO must review and ensure that data received from providers is accurate, timely, and complete. The MCO must facilitate routine tracking and trending of enrollee care issues to monitor, and assist in monitoring access, use and coordination of all services, including behavioral health services.

MCOs must submit to BMS 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 Article III, Section 5.10, Reporting Requirements).

1.2.2 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 BMS.[3] 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 in-network and 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 preauthorization is required to provide necessary medical care and enrollees may seek care from non-participating providers.

The MCO must reimburse for 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 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 women, the woman or her unborn child, in serious jeopardy; resulted in serious impairment to bodily functions; or resulted in

[3] 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.

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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 must 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 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.

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 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.

1.2.3 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 the MCO is financially responsible for if they:

- 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.
- Were obtained within or outside the organization that are not pre-approved by a plan provider or other managed care organization representative, but administered to maintain, improve, or resolve the enrollee's stabilized condition if -
    - The organization does not respond to a request for pre-approval within 1 hour;
    - The organization cannot be contacted; or

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- The organization representative and the treating physician cannot reach an agreement concerning the enrollee's care and a plan physician is not available for consultation. In this situation, the managed care organization must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria in §422.113(c)(3) is met.

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.

The MCO is required to limit charges to enrollees for post-stabilization care services to an amount no greater than what the MCO would charge the enrollee if he or she obtained the services throught he MCO.

The MCO's financial responsibility for post-stabilization care services it has not pre-approved ends when:

- A MCO physician with privileges at the treating hospital assumes responsibility for the enrollee's care;
- A MCO representative and the treating physician each reach an agreement concerning the enrollee's care.

1.2.4 Family Planning

In accordance with 42 CFR §438.206(b)(7), 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.[4]

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

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[4] 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 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.

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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, 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 BMS).

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.

1.2.4.1 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:

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 must encourage out-of-network family planning providers to coordinate services with MCO providers and to educate MCO enrollees to return to

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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.

1.2.4.2 Tubal Ligation

In accordance with Senate Bill 716, the DHHR shall make payment for tubal ligation without requiring at least 30 days between the date of informed consent and the date of the tubal ligation procedure. Tubal ligation services are excluded from MCOs' capitation rates but will remain covered Medicaid services for persons who are enrolled in MCOs. DHHR shall pay claims for tubal ligation on an FFS basis in accordance with West Virginia Department of Health and Human Resources, Bureau for Medical Services Policy 519.15, Women's Health Services.

Any licensed doctor providing these services must be compliant with the Federal Social Security Act 42 CFR §441, Subpart F – Sterilizations, §441.255 and §441.256 requirements, which requires informed consent and medical necessity.

1.2.5 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.

1.3 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.

1.3.1 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

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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 transportation as appropriate.

1.3.2 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 BMS 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. BMS will provide the MCO with pharmacy utilization data to support coordination of care for the enrollee.

The MCO remains responsible for all physician-administered drugs, such as those provided as part of an inpatient stay, a bundled ER visit, or administered vaccinations. The MCO is permitted to negotiate and collect supplemental rebates with drug companies for provider-administered drugs. The MCO's provision for physician discretion and the medical needs of the patient must not be impaired by rebate agreements. The rebate amount shall be accounted for in the MLR calculation.

The MCO shall comply with Section 1004 of the SUPPORT for Patients and Communities Act and the Drug Utilization Review (DUR) regulations as described in section 1927(g) of the Act and 42 CFR part §456, subpart K. The MCO shall be subject to both prospective and retrospective requirements, as applicable, dependent on whether the medication is administered via point of sale or clinically.

The MCO must comply with all established criteria required by WV Medicaid before approving the initial coverage of any physician-administered agent which is currently available in a point of sale form. If exceptions to the criteria are considered appropriate or necessary, the MCO must obtain written consent for such variance from BMS Office of Pharmacy Services.

The MCO shall be subject to following provisions of Section 1004 of the SUPPORT for Patient and Communities Act:

1. **Claim Reviews:**
    a. Retrospective reviews on opioid prescriptions exceeding state defined limitations on an ongoing basis.
    b. Retrospective reviews on concurrent utilization of opioids and benzodiazepines as well as opioids and antipsychotics on an ongoing periodic basis.
2. **Programs to monitor antipsychotic medications to children**: Antipsychotic agents are reviewed for appropriateness for all children including foster children based on approved indications and clinical guidelines.
3. **Fraud and abuse identification:** The DUR program has established a process that identifies potential fraud or abuse of controlled substances by enrolled individuals, health care providers and pharmacies.

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1.3.3 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. BMS will coordinate with Utilization Management vendor and Medicaid Management Information Systems (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.

1.4 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[5] and for the reversal of sterilization;
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 MCO must not reimburse for drugs, drug products, and related services, which are defined as a non-covered benefit by BMS' 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).

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[5] Infertility services are excluded per West Virginia State law, section 33-25A-4(2)(b).

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

1.5 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.[6]

MCOs and their participating providers may not bill or collect any payment from Medicaid enrollees for care that was determined not to be Medically 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 excess of the rates established by BMS 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.

1.6 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 must refer to the FFS Medicaid provider manuals available on the WV DHHR website for an explanation of service limitations under the MHT or WVHB.

1.6.1 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 2.2 of the contract.

2. PROVIDER NETWORK

2.1 General Requirements

2.1.1 Network Capable of Full Array of Services

In accordance with 42 CFR §438.206(b)(1), 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, and specialty care providers in sufficient numbers to make available all covered services as required by the availability and access standards of the contract. In accordance with 42 CFR §438.207 , the MCO must maintain a sufficient number, mix, and geographic distribution of providers.

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[6] 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.

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The MCO must contract with sufficient numbers of providers to maintain sufficient access in accordance with BMS' Medicaid managed care network standards for all enrollees, including those with limited English proficiency or physical or mental disabilities. The MCO must submit to BMS 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 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
- 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 BMS) 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 Medicaid enrollment;
- Expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented by the MCO;
- Numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services;
- Numbers of network providers who are not accepting new Medicaid patients; and
- Geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid 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 BMS, 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.

2.1.2 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. The MCO must have policies and procedures, including coverage rules, practice guidelines, payment policies and utilization management, that allow for individual medical necessity determinations.

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BMS 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 are included in Appendix I. They include adult and pediatric standards for:

- PCPs;
- Specialists;
- OB/GYNs;
- Basic hospital services;
- Tertiary hospital services[7];
- Pediatric and adult 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. BMS 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 BMS 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.

2.1.2.1 Exceptions to Network Standards

BMS 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 BMS 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.

The State will grant exceptions to MCOs based on additional documentation from the MCO that a provider may be seen out-of-network in the event a contracted provider arrangement cannot be obtained. Exceptions are monitored closely and typically only granted in instances where a provider does not exist within a specific geographic location and one in an urban area must be

[7] 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.

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leveraged; these exceptions will be applied consistently across all MCOs. The State will provide each MCO with all other MCO provider files to identify potential providers in service gap areas to help address any potential deficiencies to avoid the exemption process.

2.1.2.2 Provider Hours Operation

In accordance with 42 CFR §438.206(c)(1)(ii), 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 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).

In accordance with 42 CFR §438.206(c)(iii), when Medically Necessary, the MCO must make services available twenty-four (24) hours a day, seven (7) days a week. In accordance with 42 CFR §438.206(c)(iv), the MCO must establish a mechanism to ensure that providers comply with the access standards set forth in this contract. The MCO must regularly measure the extent to which providers in the network comply with these requirements and take remedial action if necessary.

2.1.2.3 Provider Cultural Competency Requirements

In accordance with 42 CFR §438.206(c), 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.

2.1.2.4 Timeliness of Access to Care

In accordance with 42 CFR §438.206(c)(1)(i), 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 BMS. In accordance with 42 CRF §438.206(c), the MCO must also regularly monitor its provider network's compliance with these standards, and take corrective action as necessary. Current BMS 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

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- MCOs must 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 must schedule or facilitate an appointment with the enrollee's PCP.

2.1.3 Specialty Care

The MCO must provide or arrange for necessary specialty care, including women's health services. In accordance with 42 CFR §438.206(b)(2), 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 must have a policy encouraging provider consideration of beneficiary input in the provider's proposed treatment plan.

2.1.4 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 enrollees of physician groups, the process includes:

- Procedures for initial credentialing;
- Procedures for recredentialing at least every three 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 BMS 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 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 BMS.

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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 8.1 of this Contract. The MCO must also report any health care-related criminal convictions, when disclosed, to BMS. 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.

2.1.4.1 Enrollment with the State

All network providers that order, refer, or render Medicaid covered services must enroll with BMS, through the fiscal agent, as a Medicaid provider, as required by 42 CFR §438.602(b). Enrollment with BMS 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 BMS that does not meet their credentialing or other requirements.

As part of the provider enrollment process, the fiscal agent, on behalf of BMS, 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.

2.1.5 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:

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- 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.

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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 6 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.

2.1.6 Additional Credentialing and Recredentialing Criteria for Certain Providers

2.1.6.1 Credentialing and Recredentialing Criteria for PCPs, OB/GYNs, and Other Specialists

Additional credentialing criteria for PCPs, obstetricians/gynecologists (OB/GYNs), behavioral health providers 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 BMS. 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

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3. Physician must notify the Center for Substance Abuse Treatment of the intention to treat addiction patients.

2.1.7 Service Area

All enrollees of the MCO must reside in the service area approved by BMS, set forth in Contract Appendix C. BMS' approval of the MCO's service area is contingent upon federal waiver approval (when necessary), BMS' evaluation of the MCO's provider network, and the MCO's maintenance of a Certificate of Authority to operate throughout the service area.

Reductions to the initially-approved service area can be made at BMS' discretion, based upon ongoing or periodical service capacity evaluations. If the MCO wishes to expand its service area, it must gain BMS' approval. If the MCO requests a service area expansion, it must demonstrate its capability to serve additional enrollees in the service area specified in the request. A service area expansion will be effective the first of the month after BMS confirms that additional capacity exists in the expanded service area.

The MCO must notify BMS 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 will not be permitted to reapply for participation in that service area(s) for a period of not less than one year, or such time period determined by BMS.

2.1.8 Network Changes

In addition to reporting quarterly on the size and composition of its provider networks, the MCO must notify BMS and the enrollment broker of any changes to the composition of its provider network that materially affect the MCO's ability to deliver all capitated services within fourteen (14) calendar days of such change identified. The MCO must provide BMS and the enrollment broker with advanced written notice of any PCP network deletions within fourteen (14) calendar days. The MCO must report any disenrollment of hospitals from the MCO's network to BMS immediately.

In cases of PCP withdrawals, the MCO must also provide enrollees with at least a thirty (30) calendar 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. Material changes in network composition that negatively affect client access to services and which are not corrected may be grounds for Contract termination.

2.2 Primary Care Providers (PCPs)

2.2.1 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;

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- 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.

2.2.2 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 hundered (500) adult enrollees who is accepting new patients 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 I.

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.

2.2.2.1 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, not the average across all of the MCO's PCPs. 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 BMS. 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.

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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. BMS 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 panel for PCPs with panels above two thousand (2,000) Medicaid enrollees across the program unless one (1) of the exceptions above is granted.

2.2.3 Assignment of PCP

The MCO must have written policies and procedures for assigning each of its enrollees to a PCP. At the time of enrollment in the MCO, the enrollment broker will inquire as to the enrollee's preference of PCPs (based on network information provided by the MCO). If such a preference is indicated during communications with the enrollment broker, this information will be collected as part of enrollment and included with the enrollment information given to BMS and the MCO. If no PCP selection is made, or if the selected PCP's panel is closed, the MCO must assume responsibility for assisting the enrollee with PCP selection. MCOs must make a PCP assignment within ten (10) 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 and location of residence. The MCO then must notify the enrollee 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. The MCO must confirm enrollees are aware of their PCP assignment and provide the opportunity to change their PCP assignment during the enrollee "welcome call" as defined in Article III, Section 3.5.1.

Enrollees with a disabling condition, chronic illness or who are SSI eligible, 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.

2.2.4 Types of Primary Care Providers (PCPs)

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

- Certified nurse midwives[8];
- Advanced practice nurses (e.g. nurse practitioners (NP));
- Physician Assistants (PA); and
- Physicians with the following specialties: General practice; Family practice; Internal medicine; Obstetrics/Gynecology; and Pediatrics.

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[8] 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.

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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 a enrollee and bill independently.

2.2.5 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.

2.2.6 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.

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 (1) time per month. The MCO may initiate a PCP change for a Medicaid enrollee under the following circumstances:

1. 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;
2. The enrollee's PCP ceases to participate in the MCO's network;
3. 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
4. The enrollee has taken legal actions against the PCP.

2.2.7 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.

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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.

2.3 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 adult and pediatric populations' 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 nurse practitioners and certified nurse midwives, even if such providers are not designated as PCPs.[9] MCOs must Contract with these providers to the extent practical.

2.4 Publicly Supported Providers

2.4.1 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.[10] 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, BMS 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 I. 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

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[9] 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.

[10] 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.

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sign exclusive contracts with any publicly supported providers that prevent the providers from signing contracts with other MCOs. Upon BMS 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 BMS. 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 was made for a claim within SFY 2021 but with a date of service on or after the effective date of the rate change, including dates of service in a preceding period, 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.

2.4.2 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 must 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 providing Medicaid services must have the right to participate in the MCO network, so long as such provider comply with the terms and conditions of the MCO provider Contract and provider qualification and credentialing process.

2.4.3 Critical Access Hospitals (CAH)

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

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2.4.4 Primary Care Centers

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

2.4.5 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. BMS 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.

2.4.6 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 BMS.

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. BMS 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.

2.4.7 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 BMS) 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.

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2.4.8 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[11] 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.

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 BMS. BMS 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.

2.4.9 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.

2.5 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.

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[11] Registered Nurses and Licensed Social Workers that, on behalf of medical homes of children and youth with special heath care needs, facilitate the patient and family engagement necessary for coordinated, ongoing, comprehensive care.

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2.6 Provider Services

2.6.1 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.

2.6.1.1 Responsibilities of the MCO Provider Services Department

The MCO 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 about MHT and WVHB; and
7. Educating providers in regards to 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.

2.6.1.2 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 reporting period.

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.

2.6.2 Provider Manual

The MCO must develop, distribute, and maintain a provider manual. The MCO must submit a copy of the provider manual to BMS by July 1st of each Contract year. BMS reserves the right to review and approve the MCO's provider manual. 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

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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 BMS 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.

2.6.3 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 physician incentives as specified in Article III, Section 2.8 of this contract.

The MCO must resubmit the revised model provider contracts to BMS any time it makes substantive modifications to such agreements.

At a minimum the MCO's 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;
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 provider must understand and agree that BMS 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 must 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

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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 or BMS: 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

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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 BMS: 1. all information required under the MCO's managed care Contract with BMS, 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 BMS 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 must 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 BMS 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;

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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 a 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 8.3;
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 BMS, as described in Article III, Section 8.3 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;
23. Contracts with primary care providers (PCPs) must also include a requirement that the provider have twenty-four (24)-hour PCP coverage; and
24. Language encouraging providers to use the HealthCheck screening forms and/or protocols for eligible members.

2.6.4 Provider Information Systems Support

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.

2.6.5 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 BMS on an annual basis. The survey must be submitted to prior to the conclusion of the contracting period of each Contract year, June 30th.

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2.7 Provider Reimbursement

2.7.1 General

BMS 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. BMS 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 claims submitted using the enrollee's Medical Assistance ID (MAID). The MCO must also require all 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.

2.7.2 In-Network Services

Subject to Article III, Section 2.7, 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.

2.7.3 Out-of-Network Services

Subject to Article III, Section 2.7, Timely Payment Requirement, the MCO must make timely payment 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.

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For non-emergency out-of-network services, the MCO may reimburse providers at eighty percent (80%) 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 1.2.2, 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.

2.7.4 Out-of-Network Hospital Transfers

The MCO must pay a 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.

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

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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.

2.7.6 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 BMS notification to the MCO of any changes to the CAH reimbursement rates, the MCO must update payment rates to CAH effective from the designated BMS 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 of the payment rate change.

2.7.7 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 (1) 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.

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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) 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 2.7.9.

As related to the sanction outlined in Appendix F, the MCO must meet a ninety percent (90%) threshold for timely claims payment (90% of total clean claims within 30 days), which aligns with 42 CFR §447.45 for fee-for-service Medicaid.

2.7.8 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 and 42 CFR §447.26. The MCO will track PPC data and make it available to DHHR upon request.

Other provider-preventable condition means a condition occurring in any health care setting that meets the following criteria:

(i) Is identified in the State plan.

(ii) Has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines.

(iii) Has a negative consequence for the beneficiary.

(iv) Is auditable.

(v) Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

2.7.9 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 BMS 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

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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 2.7.6 or payments made to FQHCs/RHCs per Article III, Section 2.4.1.

2.7.10 Alternative Payment Models (APM)

BMS 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 FFS reimbursement to reimbursement that rewards improved delivery of health care. In SFY 2021, the MCO is required to implement APMs that include ten percent (10%) of enrollees enrolled during the State Fiscal Year. BMS intends to increase this target in future years.

2.7.10.1 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.

2.7.10.2 APM Activities Report

The MCO is required to submit a report to BMS annually on its APM activities. The report specifications are outlined in Appendix H but must 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.

2.7.11 Requirements for Provider-Administered Drug Reimbusement

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

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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 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.

2.8 Prohibitions on Inappropriate Physician Incentives

The MCO must comply with regulatory requirements regarding physician 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 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 BMS 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 BMS 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.

3. ENROLLMENT & ENROLLEE SERVICES

The program will enroll the TANF, TANF-related populations, and adults eligible for the Medicaid Alternative Benefit Plan (ABP), including certain low-income populations eligible under the authority of the ACA. Enrollment will be handled by BMS through a Contract with the central enrollment broker. The enrollment broker is responsible for conducting outreach and

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enrolling eligible Medicaid beneficiaries into the Medicaid managed care programs. The enrollment broker will use the marketing materials furnished by the MCO as set forth in this Contract to assist enrollees in choosing an MCO. The enrollment broker will be responsible for notifying potential enrollees about their MCO choices; answering questions about the MCO; and for assisting the enrollee in completing any paperwork necessary to enroll in the MCO, to disenroll from the MCO, and to transfer from one MCO to another. The MCO will be furnished with an enrollment roster that identifies individuals enrolled in the MCO, including all new enrollees, on a monthly basis. All enrollment activities are subject to the standards and requirements set forth in this contract.

In accordance with H.B. 2266 (2021), the MCO shall provide services to pregnant women and newborns up to one (1) year postpartum, effective July 1, 2021 or as soon as federal approval has occurred.

3.1 Marketing

3.1.1 Liaison with Enrollment Broker

The MCO must designate a liaison to foster ongoing communication and coordination with the enrollment broker. The MCO will be expected to respond promptly and constructively to questions and concerns raised by the enrollment broker. The MCO must also participate in meetings or other discussions with the enrollment broker and with BMS representatives concerning client education, enrollment, and problem-solving.

3.1.2 Marketing Plan

The MCO must submit a marketing plan to BMS for prior written approval by October 1st of each Contract year. If the marketing plan is modified during the Contract year, the revised marketing plan must be submitted to BMS for written approval prior to engaging in any activities not specified in the original plan. The MCO marketing plan must comply with the BMS Marketing Policies as described in Appendix C of this Contract.

3.1.3 Marketing Materials

The MCO must follow the marketing guidelines as described in 42 CFR §438.104 and Appendix C, BMS Marketing Policies. The MCO must develop marketing materials for the enrollment broker to assist Medicaid enrollees with their MCO selection. The MCO must include a Medicaid enrollee handbook and the provider directory in the materials furnished to the enrollment broker.

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, enrollees receive accurate oral and written information needed to make an informed decision on whether to enroll. Materials must use an easily readable typeface (such as twelve (12) or fourteen (14) point), frequent headings, and must provide short, simple explanations of key concepts. Technical or legal language must be avoided whenever possible. The MCO must submit evidence to BMS that its materials satisfy this requirement[12] and provide a written assurance that marketing materials do not mislead, confuse or defraud enrollees or BMS. Such written

[12] Many commercial word processing software programs contain utilities for testing the readability of documents produced using the program.

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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, the federal or state government, or similar entity.

Marketing materials that require BMS 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.

3.2 Enrollment

3.2.1 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 MCO must accept enrollees in the order in which they apply (i.e., the order in which their enrollment information is transferred by BMS or the enrollment broker) up to the limits set by BMS. The MCO may not attempt to discourage or delay enrollment of eligible Medicaid enrollees.

3.2.1.1 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 5.3.

3.2.1.2 Confinement to an Inpatient Care Facility at Time of Enrollment or Disenrollment

Notwithstanding Article III, Section 7.6, 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 BMS until the enrollee is discharged. The MCO is responsible for all other covered services provided on or

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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.

3.2.1.3 Automatic Reassignment Following Resumption of Eligibility

Medicaid beneficiaries who lose eligibility for the West Virginia MHT or WVHB programs and regain eligibility within one (1) year will be automatically re-enrolled in the same MCO in which they were previously enrolled. BMS will perform this process and supply the necessary information to the enrollment broker. (If a previously eligible beneficiary has been ineligible for a period of time in excess of one (1) year, the beneficiary will select a plan through the standard enrollment broker process.)

3.2.1.4 Enrollment of Program Newborns

The MCO must have written policies and procedures for enrolling newborn children of Medicaid enrollees retroactively effective to the time of birth. These enrollment procedures must include transfer of newborn information to both BMS and the enrollment broker and must provide for processing completion within thirty (30) calendar days of the date of birth. Newborns of program-eligible mothers who are enrolled at the time of the child's birth will be enrolled in the mother's MCO.

The MCO is responsible for all Medically Necessary covered services provided under the standard benefit package to the newborn child or an enrolled mother for the first sixty (60) to ninety (90) calendar days of life based upon the cut-off date for MCO enrollment with the enrollment broker. The child's date of birth will be counted as day one. BMS 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 submit newborn enrollment forms to the enrollment broker within sixty (60) calendar days of the date of delivery or as soon thereafter as the MCO becomes aware of the delivery.

3.2.1.5 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.

3.2.2 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 primary care provider 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 ten (10) 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.

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The enrollee must be notified of this assignment and of the procedures for changing the designated provider. In the event that a primary care provider 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.

3.2.3 Enrollment Limits

In accordance with 42 CFR §438.206, BMS may establish a maximum Medicaid enrollment level for Medicaid beneficiaries for the MCO on a county-specific basis dependent on BMS' 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 BMS' approval. The MCO must notify BMS forty-five (45) calendar days prior to the desired effective date of the change. BMS will issue its approval or disapproval in thirty (30) calendar days, subject to BMS' 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 BMS confirms additional capacity exists. If capacity is decreased because of a reduction in the number of participating providers available to Medicaid enrollees, then BMS will give the patients of those providers leaving the network the option to voluntarily disenroll from the plan.

3.2.4 Disenrollments

The term "disenrollment" will be used to refer to beneficiaries who leave the MCO in which they are enrolled. Disenrolled beneficiaries will generally enroll in another MCO. Disenrollment may be initiated by the enrollee, MCO, or BMS.

The MCO must inform enrollees of their right to terminate enrollment through the enrollee handbook. 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 another MCO.

3.2.4.1 MCO-Initiated Disenrollment

Involuntary beneficiary disenrollment from the MCO may occur for the following reasons:

1. Loss of eligibility for Medicaid or for participation in Medicaid managed care;
2. The beneficiary's permanent residence changes to a location outside the MCO's Medicaid service area. However, if the resident moves to a location serviced by other MCOs, the resident must reenroll into a new MCO as soon as administratively possible;
3. Continuous placement in a nursing facility, State institution or intermediate care facility for the mentally retarded for more than thirty (30) calendar days;
4. 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 enrollment broker enrolled the beneficiary while their exemption request was being considered; or
5. Beneficiary death.

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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 BMS that terminations are consistent with the reasons permitted under the contract. BMS has responsibility for promptly arranging for services for any enrollee whose enrollment is terminated for reasons other than loss of Medicaid eligibility.

After BMS becomes aware of, or is alerted to, the existence of one of the reasons listed above, BMS will notify the enrollment broker of the beneficiary's loss of eligibility. In the case of continuous placement in a facility or institution for more than thirty (30) calendar days, the MCO must notify BMS within five (5) business days following the 30th day of admission. The enrollment broker will then notify the beneficiary or family and update the enrollment roster to inform the MCO of disenrollment. 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 BMS of its intent to disenroll an enrollee, the MCO must specify the reason for the request in order to assure BMS that the reason for the request is consistent with the permissible reasons specified in this contract. BMS will make the final decision to approve or deny the requested MCO-initiated disenrollment. If BMS does not act on the MCO's request for a disenrollment, the disenrollment will be considered as approved.

3.2.4.2 Enrollee-Initiated Disenrollment

MCO enrollees may request disenrollment 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. There is no limit on the number of disenrollment requests that an enrollee can initiate. The enrollee should contact the enrollment broker to initiate disenrollment. However, if an enrollee informs the MCO that he or she wants to transfer to another MCO, the MCO must work with the enrollment broker to facilitate the process. If an enrollee makes multiple requests before the next effective date, the enrollment broker will transfer the individual to the last MCO selected prior to the enrollment closing date.

If the state agency fails to make a disenrollment determination within the specified timeframes, the disenrollment is considered approved for the effective date that would have been established had the State or MCO made a determination in the specified timeframe, consistent with 42 CFR §438.56.

3.3 Enrollee Services Department

3.3.1 General Requirements

The MCO must maintain an Enrollee Services Department to assist enrollees in obtaining Medicaid covered services. The Enrollee Services Department, at the minimum, must be accessible during regular business hours, at least for eight (8) hours a day and through a toll-free phone number. The Enrollee Services Department must work with both Medicaid enrollees 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 SLAs:

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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.

If the MCO's Subcontractor operates a separate call center, the Subcontractor's call center must at a minimum meet the enrollee call center performance standards set forth in this Section.

The MCO must provide training to all call center staff on all aspects relating to the Medicaid program, including but not limited to all grievances and appeals procedures consistent with Article III, Section 3.8 (Grievances and Appeals).

3.4 Materials

3.4.1 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 6th 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 whenever taglines are necessary to ensure meaningful access by limited English proficiency (LEP) individuals to a covered program or activity and be 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 TYY/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 BMS in accordance with Article III, Section 3.7.

3.4.2 Member ID Cards

The MCO must issue an identification card for its Medicaid enrollees to use when obtaining MCO services. The card must 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. The MCO may issue one 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 a 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:

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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 enrolleee services (if different);
6. Primary care provider name and office telephone number;
7. TTY number;
8. Notice that the enrollee must present both the MCO card and the Medicaid card at time of service; and
9. The Medicaid MCO program type (e.g. MHT or WVHB).

The Medicaid identification card issued by BMS will serve as the enrollee's identification card for MCO purposes until the permanent MCO card is issued. MCO providers must ask to see both the Medicaid card and the MCO's card to verify an enrollee's eligibility and enrollment.

3.4.3 Enrollee Handbook

The MCO must mail an enrollee handbook to the new enrollee's household within five (5) business days of official enrollment notification to the MCO, provide the enrollee handbook by email after obtaining the enrollee's agreement to receive the information by email, or advise enrollees in paper or electronic form that the information is available on the internet and includes the applicable email address, provided that enrollees with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost. For enrollees previously enrolled in the MCO within the previous twelve (12) months, the MCO is not required to mail another handbook. The MCO must notify re-enrolled enrollees with information on how to obtain a new handbook upon request. The MCO must provide periodic updates to the enrollee handbook as needed explaining changes to the MCO policies or Medicaid 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 publish and keep current its enrollee handbook on the MCO website. The MCO must provide a enrollee handbook to enrollees within five (5) business days upon request. BMS will review the MCO's enrollee handbook to determine whether the materials package is approved or in need of revisions.

The MCO must use the model enrollee handbook supplied by BMS and insert MCO-specific material as directed in the template. The MCO must use the definitions included in the model handbook in enrollee communications. Copies of the MCO's enrollee handbook must be sent to the enrollment broker and BMS.

3.4.3.1 Enrollee Handbook Requirements

The handbook must include the following information which must adhere to the standards set forth in this contract:

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1. Table of contents;
2. The phone number which can be used for assistance in obtaining emergency care;
3. A description of all available MHT or WVHB 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. Grievances, appeal, and state fair hearing 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 BMS 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, waste, or abuse;
8. Disenrollment policies;
9. How to obtain EPSDT services;
10. 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;
11. Information on the process of selecting and changing the enrollee's primary care provider;
12. Information concerning policies on advance directives;
13. 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;

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14. Explanation of what constitutes an emergency medical condition and emergency services;
15. The fact that prior authorization is not required for emergency services;
16. The enrollee's right to use any hospital or other setting for emergency care;
17. Procedures for obtaining services covered under the Medicaid State Plan and not covered by the MCO (e.g., prescription drugs, non-emergency medical transportation);
18. The extent to which and how to access post-stabilization services;
19. Limited MCO liability for services from non-MCO providers, e.g., only emergency care or referrals;
20. The phone number of the enrollment broker;
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;
26. How to obtain maternity and sexually transmitted diseases services;
27. How to obtain behavioral health and SUD services;
28. How to obtain non-emergency and emergency dental services;
29. Information on enrollees' rights to access certified nurse midwife services and certified pediatric or family nurse practitioner services;
30. Procedures for recommending changes in policies or services;
31. What to do in the case of out-of-county and out-of-state moves;
32. 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;
33. 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 BMS;
34. Information on enrollee rights and responsibilities, as outlined in this contract;
35. Any significant changes, as defined by BMS, 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;
36. The MCO's policies regarding the appropriate treatment of minors;
37. The MCO must advise enrollees at least annually of their right to request and obtain the above information;

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38. Cost-sharing policies, including but not limited to exemptions for certain categories of enrollees and services; and
39. 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.

3.4.3.2 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 BMS 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.

3.4.4 Provider Directory

In accordance with 42 CFR §438.10(h), the provider directory must include the provider names, group affiliation, specialty, locations with street addresses, telephone numbers of current network providers in the enrollee's service area, website URL, whether the provider will accept new enrollees, the provider's cultural and linguistic capabilities, and whether the provider's office has accommodations for people who have physical disabilities. This information must 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 written 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 quarterly, 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. Additionally, the MCO must deliver an update of the provider directory on disk to the enrollment broker every month. 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. MCOs shall submit the provider directory annually to BMS for review and approval by October 31st.

3.4.5 MCO Internet Website

The MCO must develop and maintain a website to provide general information about the Medicaid managed care programs, the provider network, customer services, and the complaints

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and appeals process. The MCO must ensure that enrollees have access to the most current and accurate information concerning the MCO's network provider participation.

3.5 Education

3.5.1 New Enrollee Orientation

The MCO must have written policies and procedures for orienting new Medicaid enrollees about the following:

1. Covered 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 Medicaid enrollee handbook.

The MCO is required to make a best effort to contact the enrollee within forty-five (45) calendar days of the effective date of enrollment for an enrollee "welcome call." If the initial attempt to contact the enrollee is unsuccessful, the MCO must make subsequent attempts to complete the contact. The MCO must document all contact efforts and make at least three (3) contact attempts at three different times of day before considering the enrollee as unreachable.

3.5.2 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. Under MHT and WVHB, the MCO must provide tobacco cessation benefits for pregnant women, adults, and children respectively. The MCO is not required to provide weight management services; the MCO may provide these services as a value-added service except for bariatric surgery which is a covered benefit under the State Plan.

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

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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.

3.5.3 Health Screenings

The MCO may offer health screenings at community events, health awareness events, and in wellness vans to its enrollees and other enrollees of the community. In such cases, the MCO must transmit a summary of the health screening to the enrollee's assigned PCP if the enrollee is enrolled with the MCO.

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.

3.5.4 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 must 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 enrolle 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 BMS' survey and certification office.

For further information regarding advance directives, refer to 42 U.S.C. Section 1396a(w).

3.6 Enrollee Rights

3.6.1 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

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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.

3.6.2 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.

3.6.2.1 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 5.7.

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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 primary care provider from among those accepting new Medicaid enrollees in accordance with Article III, Section 3.2.

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 parent or representative to facilitate care or treatment decisions when the enrollee is unable to do so. MCOs must provide for enrollee or 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 must 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 a enrollee based on whether the enrollee has executed an advance directive;
- Ensuring compliance with requirements of state law respecting advance directives; and

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- 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.

3.7 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.

3.7.1 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 interpretative 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.

BMS 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 BMS, 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.

3.7.2 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).

3.7.3 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.

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3.7.4 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.

3.8 Grievances and Appeals

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, and must be approved in writing by BMS (42 CFR §434.32). Each MCO may have only one level of appeal for enrollees. All required notices will be developed by BMS.

3.8.1 Resolution of Enrollee Issues

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 benefit determination taken by the MCO as defined in 42 CFR §438.400(b). The MCO must submit to BMS 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 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:

   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, cancellations or non-renewals 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 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 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;

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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 ninety (90) 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 BMS 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 (c), 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. 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;

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e. The time limit for the enrollee to file an appeal is sixty (60) calendar days from the date on the notice of the adverse benefit determination;

f. 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;

g. The MCO must offer to meet with the enrollee during the grievance process;

h. 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 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 upon request. Copies of the grievances and the responses thereto must be available to the public for inspection for five (5) years;

i. 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;

j. The MCO must process and provide notice to the affected parties regarding a grievance in a reasonable length of time not to exceed ninety (90) 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;

k. Standard resolution and notice of appeals must occur with the timeframes established by BMS 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;

l. 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 of the right to file a grievance if he or she disagrees with that decision; and

m. 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-covered services, which could seriously jeopardize the enrollee's health and well-being. This includes an appeal regarding any service related to a enrollee's formal treatment plan as developed by the MCO and PCP. The MCO must report these appeals to BMS immediately, and BMS will then determine the timeline for resolving the

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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 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 BMS, to provide prompt oral notice to the enrollee, 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 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, or the timeframe specified in the West Virginia Statute 33-25A-10. 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.

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 BMS 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 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 the adverse benefit determination must be in writing and must meet the readability requirements of Article III, Section 3.4 of this contract. BMS 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;

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ii. The reasons for the adverse benefit determination, 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 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 the 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 the adverse benefit determination if:

- 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 local jurisdiction, State, territory or commonwealth;
- The enrollee's whereabouts are unknown and the post office returns the enrollee's mail indicating no forwarding address;
- The enrollee's physician has changed the level of care prescribed;
- the notice involved an adverse determination made with regard to the preadmission screening requirements for NF admissions on or after January 1, 1989;
- 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 actions for NF transfers); or
- The date of the adverse benefit determination will occur in less than ten (10) calendar days in accordance with 42 CFR §438.12.

iii. For adverse benefit determination due to probable fraud by the enrollee, no later than five (5) calendar days in advance of the action;

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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 BMS as delegated to the West Virginia Board of Review[13]. 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 State, 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 State'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 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;

[13] 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

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- The services were ordered by an authorized provider;
- The original period covered by the original authorization has not expired; and
- 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;
- Other than the exceptions above, within thirteen (13) calendar days after the MCO mails the notice of resolution of the appeal of an adverse benefit determination against the enrollee, unless the enrollee within the thirteen (13) calendar day timeframe, has requested a state fair hearing with continuation of benefits until a state fair hearing decision is reached;
- The time period or service limits of a previously authorized service have been met; 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 BMS 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.

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.

3.9 Cost-Sharing Obligations

The MCO, through the MCO's providers, must impose copayments for covered services in the amounts that are determined by BMS in accordance with the requirements specified in the 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).

3.9.1 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;

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- 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.

3.9.2 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 a nurse practitioner or physician assistant;
- Non-emergency use of an emergency department;
- Caretaker relatives age twenty-one (21) and up;
- Transitional Medicaid enrollees age twenty-one (21) and up; and
- Any other enrollees identified by the MCOs that are not specifically exempt.

3.9.3 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. For FQHCs, the payment shall be defined as the allowed amount ("encounter rate") less the primary paid amount without consideration of cost-sharing.

3.10 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 BMS. 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

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MCO capitation rates. The Value-Added Services are not included in the Medicaid benefit package.

Value-Added Services must be approved by BMS. The MCO may submit the proposed Value-Added Services bi-annually on the following schedule:

- By October 1st of each calendar year for the January 1st publishing date; and
- By April 1st of each calendar year for the July 1st 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, there is no appeal or fair hearing rights for a 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.

3.11 Population Health

The MCOs shall participate in, and support, BMS's efforts to address population health and eliminate health disparities in West Virginia. According to the U.S. Department of Health and Human Services', and for the purposes of this Contract, a health disparity is "a particular type of health difference closely linked with social, economic, and/or environmental disadvantage."[14] Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health based on characteristics historically linked to discrimination or exclusion (i.e. race or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive; sensory or physical disability; sexual orientation; or geographic location). The MCO shall collect and meaningfully use member-identified race, ethnicity, language, and social determinants of health data to identify and reduce disparities in health care access, services, and outcomes.

[14] "Disparities", the Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services, https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities#:~:text=Healthy%20People%202020%20defines%20a,%2C%20and%2For%20environmental%20disadvantage.

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3.11.1 Social Determinants of Health (SDoH)

MCOs shall endeavor to enhance integrated physical and behavioral health care, active local involvement, and focus on enrollees and family through proactive case management activities that support enrollees living in their homes and community, increase enrollees' self-sufficiency, and address SDoH needs. The MCO shall develop strategies to address the SDoH impacting enrollees.

3.11.1.1 Assessment of SDoH Needs

The MCO shall screen enrollees for Social Determinants of Health (SDoH) risk factors and properly refer enrollees to community-based resources based on assessed need. Enrollees must be screened during the initial health risk assessment and then annually to reassess SDoH needs past initial enrollment. Care coordination and care management assessments and reassessments must also address SDoH and any needs shall be documented in care plans. The SDoH screening and referral process shall include, but not be limited to aspects such as enrollee housing and utilities status, food insecurity, transportation availability, and employment status.

If the MCO identifies any SDoH needs and refers enrollees to external entities (e.g., community-based organizations, local non-profits), it must follow up with enrollees to document the completion of enrollee's referral and the successful provision of services. The MCO will ensure that SDoH needs are addressed in culturally appropriate ways, with accessibility to all resources and services rendered.

3.11.1.2 MCO Staff and Training Requirements

The MCO staff (including care management and enrollee services staff) and contracted providers shall receive training in the following areas:

- Specific training on care coordination job functions with an annual refresher training on motivational interviewing;
- Bi-annual training on cultural competency and implicit bias;
- Annual training on customer service; and
- Additional training relative to SDoH case management that the MCO deems necessary.

The trainings listed above do not replace or subvert training requirements to educate MCO staff and contract providers on how to recognize and screen for enrollees SDoH needs, why addressing enrollees SDoH needs is important, how it impacts enrollees care, and how to connect enrollees with available community resources and social services. MCOs shall maintain records of staff trainings at all times.

3.11.1.3 Partnering with Community Based Organizations (CBOs)

The MCO must collaborate and build partnerships with community-based organizations, public health departments or social service providers to implement person-centered SDOH interventions that integrate physical and behavioral services and supports access to care. In additon, the MCOs shall maintain a list of community resources and social services including key contact information to assist staff and providers with enrollee referrals.

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3.11.1.4 Addressing SDoH Through Technology, Data Collection and Analytics

The MCOs must make SDoH data collected through assessments, care management touch points and claims data to BMS upon request. This includes, but is not limited to, encouraging contracted providers to use ICD-10 Z-codes on provider claims.

The MCOs are required to perform data analytics to identify enrollees' disparities and implement and report on the effectiveness of evidence-based interventions that are designed to address enrollees SDoH. This includes, but is not limited to:

- Number of enrollees experiencing a disparate level of social needs such as transportation, housing, food access, unemployment, or education level;
- Number of enrollees receiving additional support services from community health workers and/or patient navigators; and
- Number of enrollees enrolled in health promotion and prevention programs delivered by a community-based organization.

4. 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 populations and cultural sensitivity. The person(s) serving as Medicaid Administrator(s) need not be dedicated full-time to this function, but must commit sufficient time to fulfilling the requirements of the position. 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 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 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;

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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.

5. HEALTH CARE MANAGEMENT

5.1 Second Opinions

In accordance with 42 CFR §438.206(b)(3), 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.

5.2 Out-of-Network Services

In accordance with 42 CFR §438.206(b)(4), 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. In accordance with 42 CFR §438.206(b)(5), 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 through in-network providers. To the extent possible, the MCO must encourage out-of-network providers to coordinate with the MCO with respect to payment.

5.3 Continuity and Coordination of Care

In accordance with 42 CFR §438.208(b)(1), the MCO must ensure an integrated approach to the continuity and coordination of care through use of an individual or entity that is formally designated as having primary responsibility for administering the enrollee's overall health care services; the MCO must provide the enrollee with information on how to contact the designated individual or entity.

The MCO must submit its care coordination program description in writing for BMS review and approval annually on October 1. If the MCO makes significant changes to its care coordination program, it must submit any changes to BMS for approval prior to implementing the change.

1. The MCO's care coordination program must describe the following components: MCO's care coordination staffing, including the number of staff by role, qualifications, and physical location;

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2. Training topics and frequency of training provided to MCO care coordination staff;
3. MCO's risk stratification framework, including the criteria and threshold for each tier;
4. Assignment of MCO care coordination staff, including caseloads by risk stratification and assignment methodology;
5. MCO's requirements related to required periodic EPSDT schedules;
6. MCO's roles and responsibilities to support Care Coordination Entities (CCEs) in providing care coordination to the MCO's enrollee and ensuring the enrollees' needs are met;
7. MCO's roles and responsibilities for performing care coordination activities when the MCO is exclusively providing care coordination to enrollees;
8. How the MCO will notify enrollees of care coordination assignment;
9. MCO's data and information systems and how they will be used to support MCO's responsibilities for care coordination regardless of which entities are providing care coordination; and
10. How the MCO will monitor the care coordination program for individual and systemic improvements.

The MCO must have documented procedures to:

1. Ensure the services that the MCO provides to the enrollee are integrated with services provided by other MCOs;
2. Ensure a comprehensive case management approach is applied; and
3. Communicate clinical information among providers in a timely manner for efficient treatment and follow up.

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 social services locally available through contracting or non-contracting with providers in the area served by the MCO. The MCO must 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 another MCO or FFS, the MCO is required to provide clinical information to the MCO or BMS, as appropriate, to promote continuity of care.

5.3.1 Initial Health Assessment

In accordance with 42 CFR § 438.208(b)(3), the MCO is required to make a best effort to conduct an initial screening of each enrollee's health care needs, within forty-five (45) calendar days of the effective date of enrollment for all new enrollees. If the initial attempt to contact the enrollee is unsuccessful, the MCO must make subsequent attempts to complete the assessment. The MCO must document all contact efforts and make at least three (3) contact attempts at three

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different times of day before considering the enrollee as unreachable. The MCOs may conduct the enrollees initial screening during the enrollee "welcome call" as defined in Article III, Section 3.5.1.

In accordance with 42 CFR § 438.208(b)(4), the MCO shall share with BMS or other MCOs serving the enrollee the results of the initial health assessment to prevent duplication. The results shall be transmitted in the timeframe and format required by BMS. The MCO must ensure that it maintains and shares, as appropriate, an enrollee health record in accordance with professional standards. In accordance with 42 CFR §438.208(b)(6), the MCO must ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with all applicable privacy laws, including but not limited to the privacy requirements in 45 CFR Parts 160 and 164 subparts A and E to the extent they are applicable, and the requirements of 42 CFR §§ 2.1 – 2.67.

5.3.2 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 1.2; 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.

In accordance with 42 CFR §438.208(c)(2), the MCOs must implement mechanisms to assess each Medicaid enrollee in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. To determine the needs of the enrollee, the MCO must consider information from the enrollee's health risk assessment and other available information. At a minimum, the criteria and thresholds must include the following current and historical factors: acuity of chronic conditions, substance use and mental health disorders, maternal risk (e.g., prior preterm birth), inpatient and emergency department utilization, SDOH, and safety risk factors.

The MCO must establish and operate an integrated Population Health Program based upon risk stratification of the MCO population. The Population Health Model touches enrollees across the entire care continuum, promoting healthy behaviors and disease self-management as well as providing care coordination and intense care management as needed and supported by evidence-based medicine and national best practices. The MCO must evaluate the entire enrollee

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population and identify enrollees for specific programs according to risk rather than disease specific categories. This approach shall include the following risk levels and programs:

- Risk Level 0: Wellness Program
- Risk Level 1: Low Risk Maternity, Health Risk Management and Care Coordination programs; and
- Risk Level 2: Chronic Care Management, High Risk Pregnancy and Complex Case Management programs

The MCO must assign an initial risk stratification tier within the first forty-five (45) days of enrollment for enrollees newly enrolled with the MCO. The MCO must review and update the risk stratification tier following the completion of the enrollee's health risk assessment.

The MCO must develop a care plan for all youth aged eighteen (18) and under to monitor progress towards select person-centered goals based on the enrollee's level of acuity. For enrollees with low acuity, the MCO shall, at a minimum, monitor whether all preventive care and associated services have been received based on the appropriate periodicity schedule, and work with the enrollee and the enrollee's guardian or authorized representative to develop person-centered goals and intervention strategies to improve access if not received. For enrollees with higher acuity, the MCO must work with the enrollee and enrollee's guardian or authorized representative (if applicable) to develop person-centered goals, identify barriers and establish interventions to assist in addressing the specific needs of the youth in meeting their needs.

For enrollees referred to Psychiatric Residential Treatment Facility (PRTF) services, the MCO shall establish an internal committee comprised of physicians and enrollees of the Department to determine if placement is most appropriate to meet the needs of the youth , or if outpatient and community-based resources can be established to meet the needs of the youth. The MCO shall also be required to implement a systematic administrative process to coordinate access to services, including non-capitated services, such as wraparound services or other programs offered by the Department to help keep the enrollee in their home and reduce residential placements. The MCO must coordinate with the Department to identify important resources to help enrollees in maintaining health and well-being.

The MCO must have a comprehensive written assessment procedure for enrollees accessing PRTF-levels of care, including development of a discharge plan. Each enrollee that enters a PRTF must have a thorough assessment completed by the provider, a subsequent plan of care, and a written discharge plan. The MCO must evaluate and prepare a enrollee for discharge thorough the following mechanisms:

1. Coordinate with the psychiatric residential treatment providers, treating professionals and the enrollee or guardian to plan enrollee's care and discharge;
2. Coordinate with the Department on Medicaid and non-Medicaid services, to be provided to the enrollee to help keep the enrollee in their setting of choice, as appropriate;
3. Coordinate community resources upon discharge;
4. Coordinate with non-PRTF providers to deliver MCO-covered services; and
5. Submit demographic data on the enrollee, including ethnicity and LGBTQ status, if available, to help with monitoring disproportionate utilization of these services.

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The MCO must provide coordination services to assist enrollees in arranging, coordinating, and monitoring all medical and support services. Each PCP is to act as the coordinator of care for his/her patients' overall care, and this requirement needs to be included in provider contracts.

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 includes:

1. Assessing enrollees' risk of readmission or deterioration in order to determine the level of care needed;
2. Identifying medical procedures to address and/or monitor the conditions;
3. Developing treatment plans appropriate for those enrollees determined to need a course of treatment or regular care monitoring;
4. Coordinating hospital admission/discharge planning and post-discharge care and continued services (e.g., rehabilitation);
5. Providing assistance to enrollees in obtaining behavioral health and community services; and
6. Providing assistance in the coordination of behavioral health, physical health, and all other services.

The MCO must assist any enrollees 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 (the MCO must make at least three (3) contact attempts at three different times of day) 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 (the MCO must make at least three (3) contact attempts at three different times of day) to engage any enrollee exiting a drug rehabilitation program to determine whether employment assistance or other support is needed. If so, the MCO must coordinate a referral to a local workforce agency and facilitate linkages to other related community supports available. If the member is unable to be reached during the discharge planning process, the MCO must engage the inpatient facility case worker to coordinate for discharge supports.

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 as a result of care coordination decisions as discussed in this subparagraph must specify the criteria used in denying or limiting authorization and include information on how to request and appeal or grievance of the decision pursuant to the procedures required in this Contract. The notice to the enrollee must be in writing.

5.3.3 Coordination of Care with Other Entities

5.3.3.1 Family Planning

Family planning services will be tracked, coordinated and monitored by the MCO. The MCO will assume one hundred percent (100%) financial risk for these services. BMS will not be responsible for any lapse in reimbursement for family planning services. Through its

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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 BMS.

Pursuant to West Virginia Code §16-2B-1, the MCO shall not require multiple office visits or prior authorizations for a woman who selects long-acting reversible contraceptive (LARC) methods unless Medically Necessary. The MCO shall provide payment for LARC devices and their insertion, maintenance, removal, and replacement. The MCO may not present barriers that delay or prevent access, such as prior authorizations or step-therapy failure requirements. Enrollees shall be able to access patient-centered education and counseling on all FDA-approved birth control methods.

5.3.3.2 Fee-For-Service (FFS) Health Care

The MCO must follow established Medicaid procedures and provide referrals and assistance in scheduling appointments to enrollees in need of 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 BMS for linking the services provided by the MCO to those non-covered services. These services will be tracked and monitored by the plans and BMS through submission of encounter forms to BMS.

5.3.3.3 WIC Program

The MCO must work with BMS 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 after referral) transfer of enrollee's medical information (length/height, weight, hemoglobin, and medical condition which influences consumption, adsorption, or utilization of food nutrients) to WIC and comply with all State and Federal privacy laws in doing so.

5.3.3.4 School-Based Health Services

MCOs must work with the providers of school-based health services to coordinate care.

5.3.3.5 Community and Social Services

The MCO must have programs for coordination of care that include the integration of services with community and social services generally available through contracting or non-contracting providers in the local community served by the MCO. The MCO shall develop a process that promotes community integration of enrollees who have select risk factors including, but not limited to homelessness; at risk of homelessness and substance use. The level of community coordination will vary in scope and frequency depending on the enrollee's level of care/need.

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5.3.4 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 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.

In accordance with 42 CFR §438.208(c)(4), for enrollees with special health care needs determined through an assessment (described in Article III, Section 5.3.1) who need a course of treatment or regular care monitoring, the MCO, must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.

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. The treatment plan must meet applicable quality assurance and utilization standards. In accordance with 42 CFR §438.208(c)(3), 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.

The MCO must share the MCO's assessment of enrollees with special health care needs with other MCOs serving 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 enrollees and PCP to facilitate specialty referrals, coordinate hospital admission/discharge planning, post-discharge care and continued services (e.g., rehabilitation), and to coordinate with services provided on a FFS basis.

5.3.4.1 Care Coordination with the Title V State Agency

The MCO, through BMS, 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 enrolled 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 appropriate 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;

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5. Make all reasonable efforts to assure Medicaid children and their established plans of care are being met.

BMS; the Bureau for Public Health's Office of Maternal, Child and Family Health (OMCFH); and the MCO will establish a Memorandum of Understanding 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 or personal health information 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 and regulatory privacy requirements, including, but not limited to, 45 CFR parts §160 and §164 subparts A and E.

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 must accept the clinical evaluations conducted by the Bureau for Public Health'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 OFCMH will coordinate services with the nutritional foods' vendor and the State's fiscal agent. The MCO is responsible for providing medical food services for all other enrollees as otherwise consistent with the West Virginia Medicaid State Plan.

5.3.5 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. If the enrollee chooses to participate, the MCO must facilitate a referral to the health home. BMS must provide monthly Health Home enrollment lists to each 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 by the MCO within twenty- four (24) hours 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.

5.3.6 Transition of Care

In accordance with 42 CFR. § 438.208(b)(2)(i), the MCO must have a transition of care policy to ensure continued access to physical and behavioral health services during a transition to or from

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FFS to a MCO, transition from one MCO to another, or between settings of care when an enrollee, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization. The MCOs transition of care policy must, at a minimum, meet BMS's defined transition of care policy and be in compliance with Federal requirements as specified in 42 CFR § 438.62 (b). The MCO's transition of care policy must ensure compliance with 42 CFR § 438.62(b)(1)(vi) regarding the process for the electronic exchange of, at a minimum, the data classes and elements included in the content standard adopted at 45 CFR §170.213 (see Article III, Section 5.10 Reporting Requirements for more detail). In accordance with 42 CFR §438.208(b)(2), the MCO is required to identify and facilitate transitions for enrollees that are moving from one MCO to another MCO or from the MCO to FFS or to private insurance and require additional or distinctive assistance during a period of transition. When relinquishing enrollees, the MCO must cooperate with the receiving MCO, FFS program or private insurance plan regarding the course of on-going care with a specialist or other provider. Priority will be given (in no specific order) 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 has 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 program, and is permitted to retain their current provider for a period of thirty (30) 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 5.4.1.

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 5.4.1.

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The MCO will develop a method for evaluating risk of readmission or deterioration in order to determine the intensity of follow up required for the enrollee after the date of discharge,. 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 accordance with 42 CFR §438.208, the MCOs must have in place 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.

5.4 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 and requirements for parity in mental health and substance use disorder benefits in 42 CFR § 438.910(d). In accordance with 42 CFR § 438.210(b), the MCO and any applicable Subcontractors 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, approve, or deny the provision of medical services. The plan must have mechanisms to detect and address both under-utilization and over-utilization of services and share monitoring and strategies with BMS upon request. 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. In accordance with 42 CFR §438.210(a)(3)(i), 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 BMS. As stated in Article II, Section 4.10 of this Contract, and in accordance with 42 CFR §438.210(a)(3)(ii), 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 must 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.

In accordance with 42 CFR §438.210(c), the MCO must make authorization decisions and in the event of an authorization denial, provide written notice to the requesting provider and enrollee as

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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. In accordance with 42 CFR §438.210(d)(1), this seven (7) calendar day period may be extended up to fourteen (14) additional calendar days upon request of the enrollee or provider, or if the MCO justifies to BMS 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%) Service Level Agreement (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.

In accordance with 42 CFR §438.210(d)(2), 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) additional 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 BMS 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 (DME) 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.

In accordance with 42 CFR §438.210(e), 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.

The standards in this subsection are designed to be guidelines consistent with best practices and W. Va. §33-25A-8s. In the event there is a conflict between this contract and the standards in W. Va. §33-25A-8s, the standards in the West Virginia Code control.

5.4.1 Service Authorization Continuity of Care

The MCO must ensure that the care of 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

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to policies and procedures affecting the service authorization process without the required notice period.

Upon the receipt of the prior service authorization documents from an enrollee or provider of the related to services when the enrollee was enrolled in a different MCO or FFS, the MCO must ensure enrollees receiving services through a service authorization from either another MCO or FFS program 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.

5.5 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 necessary service or type of provider, in terms of training, experience, and specialization, is not available within the MCO network;
- The enrollee's primary care provider or other provider determines that the enrollee needs related services that would subject the enrollee to unnecessary risk if such services were received separately, and not all of the related services are available within the network; or

BMS 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.

A provider in the circumstances described above 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 sixty (60) or ninety (90) calendar days, respectively, of enrollment, after being given an opportunity to select a participating provider.

5.6 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 BMS-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.

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5.7 Practice Guidelines and New Technology

Pursuant to 42 CFR § 438.236, 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 must 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 practice guidelines.

The MCO must develop and implement written policies and procedures for evaluating new medical technologies and new uses of existing technologies.

5.8 Enrollee Medical Records and Communication of Clinical Information

In accordance with 42 CFR §438.242(c), the MCO must compile and maintain, in a centralized database, encounter-level data on the services rendered by individual providers to enrollees and submit this information to BMS. MCOs must submit enrollee encounter data to BMS at a frequency and level of detail as requested by CMS and BMS, based on program administration, oversight, and program integrity needs, including enrollee encounter data that BMS is required to report to CMS under 42 CFR § 438.818. Encounter data must be submitted in the standardized ASC X12N 837 and NCPCP formats, and the ASC X12N 835 format as appropriate. 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 an initial assessment of each enrollee's health care needs is completed within ninety (90) calendar days of the effective date of enrollment. The MCO must ensure that each provider furnishing services to enrollees maintains the enrollees' health records. PCPs must establish and maintain a confidential, centralized medical record for each enrollee that details care received. Each enrollee medical record must 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 taking into account professional standards and best practices.

These standards and best practices 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 §438.208(b)(5);
- 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;

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- 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 must be 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 use 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 visits, 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.

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Medical records must be legible, meaning the record is legible to someone other than the writer. Any record judged illegible by one physician reviewer must 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, privacy protected, exchange of information among providers, such that a provider making a referral is able to transmit necessary information to the provider receiving the referral, a provider furnishing referral service is able to report appropriate information to the referring provider, and ensure all providers are able to 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 to be transferred to the new provider in a timely manner that ensures continuity of care.

The MCO must have policies and procedures in place to ensure that the identification and assessment of enrollee's needs are promptly shared with the State, other MCOs and private insurers and make all efforts to prevent duplication of these activities.

5.9 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 and §164, 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.

5.9.1 Establishment of Confidentiality Procedures

To this end, the MCO must establish 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.

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5.9.2 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 BMS staff and to BMS 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.

5.10 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 BMS 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 MHT and WVHB program-related data only unless otherwise requested by BMS.

The MCO must certify data submitted to BMS and an authorized agent of BMS, if such data is the basis upon which BMS 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 format for the data certification is included as Appendix E. The data that must be certified include, but are not limited to, enrollment information, encounter data (both monthly proprietary submissions and weekly 837 transactions), and other information required by BMS and contained in contracts, proposals, and related documents.

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5.10.1 Quarterly Reports

The MCO must provide BMS with quarterly reports summarizing provider network, utilization, quality, access, EPSDT, and financial data in formats to be specified by BMS, no later than by the 15th day of the second (2nd) 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.

5.10.2 Grievance and Appeals Reporting

The MCO must provide BMS with quarterly reports documenting the number and types of grievances and appeals, the turnaround times, and other defined metrics, utilizing the required grievances, appeals and denials (GAD) template. Reports must be submitted no later than 105 days after the end of the reporting quarter to allow for completion of the 90 day resolution period and 15 days to complete report development. MCOs shall submit required files from the GAD universe report within 30 days submission of the GAD universe report.

5.10.3 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.

5.10.4 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 must support reporting of the U.S. DHHS' Core Quality Measures for Adults and Children. The MCO must use content or methodology as directed by BMS. The MCO must submit to BMS a copy of any results provided by the 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 BMS annually, on or before August 15th. 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 BMS. If BMS requires any additional measures to be reported from the survey results, BMS 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 15th, the MCO must submit its action plan to BMS. The action plan must include implementation steps, a timeline for completion, and any other elements specified by BMS. Along with the action plan, the MCO must submit an evaluation describing the effectiveness of the previous years' interventions.

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5.10.5 Encounter Reporting

The submission of complete and accurate encounter data is a condition of capitation payment to the MCO by BMS.

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 BMS or its contractors on the submission of encounter data and resolution of any data issues.

5.10.5.1 Encounter Data Submission

All encounters, inclusive of both allowed and paid amounts, must be submitted in electronic or magnetic format specified by BMS. The format will be consistent with the formats and coding conventions of the CMS 1500 and UB92/UB-04 if and until BMS 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 BMS. 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 must be used in all encounter data submissions. The encounter data set will include at least those data elements as specified by BMS 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.

5.10.5.2 Changes to Encounter Data

The MCO will be required to comply with any changes that BMS intends to implement within sixty (60) calendar days of issuance, unless otherwise agreed to in writing by BMS within thirty (30) calendar days of issuance.

The MCO must provide BMS 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 BMS to ensure consistency of encounter data.

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5.10.5.3 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 BMS;
- 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 BMS for review and approval by October 1st for the current fiscal year. This Plan must include the three (3) elements listed above. Along with this submission, the MCO must submit documentation of its data file layout.

The MCO must provide complete, accurate, and timely encounter data to BMS. 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 BMS. If the MCO fails to meet a ninety-five percent (95%) encounter acceptance rate, it will be assessed a liquidated damage of $100 for each rejected encounter below the ninety-five percent (95%) acceptance rate as noted in Appendix F.

5.10.6 Healthcare Effectiveness Data and Information Set (HEDIS) Reporting

The MCO must report audited HEDIS measures to BMS annually by June 15th. Once the MCO performs NCQA's HEDIS Compliance Audit, the audited results must be submitted to BMS upon submission to NCQA. BMS will provide guidance to MCOs regarding which measures must be reported, according to the current version of HEDIS.

5.10.7 National Core Health Care Quality Measures Reporting

The Secretary of 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 BMS 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 1st. The MCO must use the most recent technical specifications from CMS, available at www.medicaid.gov, to calculate results.

5.10.8 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 1st, 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

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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 7.

5.10.9 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 BMS.

5.10.10 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 tDHHR. The three (3) 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 BMS, by October 1st, 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.

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5.10.11 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 BMS. (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 BMS each year by October 1st attesting 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.

5.10.12 Annual Report

The MCO must submit its annual report to BMS by April 1st. The MCO must also make copies of the annual report available on its website and to its enrollees upon request.

5.10.13 Data Necessary for Drug Rebate Collection

For provider-administered drugs provided under managed care, the MCO must submit to BMS the drug utilization data necessary for the collection of drug rebates in formats and data layout to be specified by BMS, as well as re-submitting encounter data as described by Article III, Section 5.10.5. The data must include, but is not limited to the following for each provider-administered drug claim:

- A HCPCS code,
- A HCPCS quantity,
- A NDC number,
- The NDC unit of measure, and
- The NDC quantity.

The MCO must resolve any rebatable encounter rejections or disputes within sixty (60) calendar days from notification of BMS or its designee. The MCO must designate a single point of contact responsible for resolving any disputes or deficiencies resulting in a rejection or labeler dispute. MCOs must engage resources such as pharmacists or pharmacy technicians to ensure compliance with the Federal and State Medicaid Drug Rebate Programs.

BMS may return encounters subject to a rejection or labeler dispute to the MCO for correction, reprocessing, and resubmission. BMS will provide the MCO a monthly PRIMS (Pharmaceutical Rebate Information Management System) encounter rejections report no later than the fifteen (15) calendar days following the end of each month listing all encounters subject to a rejection. The MCO must resolve rebate-eligible encounters on the PRIMS reject report within 60 calendar days from the date of notification by BMS or its designee.

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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 Bureau for rebate processing. The MCO must use the data provided on this crosswalk as a reference, not the sole authority when making drug coverage determinations. MCOs must independently ensure that the drug coverage meets the definition of a covered-outpatient drug, which includes verifying that the manufacturer of the drug has an active Federal drug rebate contract via third-party vendors and/or publicly available Federal resources (including data.medicaid.gov). Instances where an inaccuracy on the crosswalk is found to result in failure of a claim to be accepted by PRIMS will not be considered a rejection. Any potential inaccuracy noted by the MCO on this crosswalk must be reported to BMS immediately.

Each encounter containing a drug filled from 340B stock must include a 340B indicator, supplied by the provider at the time of billing, verifying whether or not a 340B drug was dispensed or administered to the Medicaid enrollee. The MCO must report this information using a standardized file layout supplied by BMS. The MCO must validate their 340B drug costs claim data by confirming that drug costs for 340B drug encounters do not exceed non-340B costs for the same drug and provide quarterly attestation that the verification has been completed.

Drug rebate encounters are included in the overall 95% encounters acceptance standard outlined in Article III, Section 6.4 and subject to the relevant liquidated damages outlined in Appendix F.

5.10.14 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 will be specified by DHHR, with reporting occurring on an annual basis.

5.10.15 Other Reporting Requirements

The MCO must submit to BMS 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. BMS will provide additional guidance on specific layouts and frequency.

The MCO must submit to BMS 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.

6. 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

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enrollee satisfaction. Such improvements must be sustained over time. QAPI strategies must 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 BMS as required by BMS. 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 BMS 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 BMS. 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.

6.1 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 BMS. 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 BMS.

6.2 Performance Improvement Projects (PIPs)

In accordance with 42 CFR §438.330, 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 MHT and WVHB (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;

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identifying and implementing appropriate system interventions to improve performance; and repeating data collections to assess the continuing effect of interventions.

6.2.1 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; and
- Effectiveness of communications with enrollees.

6.2.2 Projects

The MCO must initiate[15] and maintain performance improvement projects that address the focus areas specified above. The MCO must maintain at least three (3) projects at a time. The performance improvement projects may be selected by BMS or required by CMS. In cases where BMS 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 BMS and the EQRO prior to project initiation.

The topics must be identified through continuous data collection and analysis; systematically selected and prioritized to achieve the greatest practical benefit for enrollees; and reflect the 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 must 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,

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[15] 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).

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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 BMS using BMS-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 MCOs 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 BMS. Project reports must be reported by July 15th 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 one-hundred twenty (120) calendar days after the end of each quarter. The report must follow the BMS-approved format.

6.3 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 BMS). 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 must 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

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- 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, patient education and enrollee services.

6.4 Health Information System

In accordance with 42 CFR §438.242(b), the MCO must maintain a health information system that collects, integrates, analyzes, and reports data in compliance with Section 1903(r)(1)(F) of the Act and as 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 Medical Assistance ID (MAID) generated by BMS 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 BMS and upon request, to CMS in compliance with Section 6504(a) of the ACA.

The MCO may establish a participation agreement with the WV Health Information Network to exchange data on an agreed upon schedule with the vendor.

6.5 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.

6.5.1 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

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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.

6.5.2 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.

6.5.3 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.

6.5.4 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 must be sought from the outset of the MCO's QAPI program planning.

6.5.5 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

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- Providing feedback to providers and plan staff regarding performance and enrollee satisfaction surveys.

6.5.6 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 must 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 must 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 BMS a written evaluation of its QAPI program strategy by June 15th of each year.

6.6 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 BMS 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 BMS 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.

6.7 Performance Profiling

BMS 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. BMS will allow the MCO opportunity to review its data for accuracy and/or validity prior to publication.

7. FINANCIAL REQUIREMENTS & PAYMENT PROVISIONS

7.1 Solvency Requirements

The MCO must make provisions against the risk of insolvency and assure that neither enrollees nor BMS 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 BMS in accordance with BMS' required formats and timing.

The MCO must maintain a fiscally sound operation as demonstrated by the following:

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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 BMS 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 BMS 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 BMS 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 BMS.

7.2 Capitation Payments to MCOs

7.2.1 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 and will not be permitted to collect any additional premiums from enrollees. Contract Appendix B contains a listing of MHT and WVHB capitation rates. BMS will automatically make capitation payments to the MCOs each month based on membership. BMS expects to process payments on the 16th and make capitation payments on the 20th of each month. MCOs will be required to submit a quarterly invoice to reconcile any differences between the capitation payments made by BMS and actual membership.

BMS 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) calendar day written notice. BMS 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 BMS 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 date of an enrollee will always be on the first day of the month (with the exception of newborns), and the enrollment termination date for an enrollee will always be the last day of the month. 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

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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 BMS 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 BMS 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 BMS).

7.2.2 Risk Adjustment

BMS, in its sole discretion, may implement a Risk Adjustment methodology in accordance with 42 CFR §438.5.

If Risk Adjustment is applied prospectively or retrospectively, BMS must select a Risk Adjustment methodology that uses generally accepted models and must apply it in a budget neutral manner, consistent with generally accepted actuarial principles and practices, across all MCOs in the program to calculate adjustments to the payments as necessary.

7.3 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 an 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 combined MLR report that will be used for rebating purposes in addition to separate detail broken out for the MHT and WVHB 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;

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- Methodology(ies) used for allocation of expenses;
- Any credibility adjustment applied;
- MLR calculated by the MCO;
- If applicable, any remittance owed to BMS;
- 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; and
- Total enrollee months.

A combined MLR percentage of less than eighty-five percent (85%) must be one hundred percent (100%) reimbursable to the State. The MCO is responsible for a fifty percent (50%) share of any MLR less than eighty-eight percent (88%) but greater than eighty-five percent (85%) percent.

7.4 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.

7.5 Third Party Liability (TPL)

Under Section 1902(a)(25) of the Social Security Act, BMS 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 must 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 must 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.

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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 BMS on the 15th of each month by submitting an electronic file, in a format to be specified by BMS, listing these identified TPL cases. For these cases, BMS 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 BMS, including status updates on any cases identified for pursuit to BMS on a monthly basis. The MCO must contact BMS if it becomes aware that an enrollee has become eligible for Medicare while on Medicaid. It must also notify BMS 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.

7.5.1 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 ninety (90) 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
- **Pediatric Preventive Services -** for claims for pediatric preventative services, unless BMS has made a determination related to cost effectiveness and access to care that warrants cost avoidance for ninety (90) calendar days.
- **Right from the Start (RFTS) –** for claims for RFTS services

The MCO must use standard coordination of benefits cost avoidance when processing prenatal services claims. If the MCO has determined that a third party is likely liable for a prenatal claim, it must reject, but not deny, the claim, returning the claim back to the provider noting the third party that the MCO believes to be legally responsible for payment. The provider may submit a claim to the MCO for any remaining balance.

7.6 Special Payment Arrangements

7.6.1 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 admission

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(e.g., MCO, BMS). 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 BMS 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 BMS. 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 BMS' 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 7.6.1, Responsibility for Inpatient Care, does not apply to behavioral inpatient and residential care services.

7.6.2 Loss of Medicaid Eligibility

The MCO is not responsible for the inpatient facility charges for an enrollee who is no longer eligible for Medicaid coverage as of the first of the month following the loss of Medicaid coverage.

7.6.3 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

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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.

7.6.4 Maternity Kick Payments

BMS may provide special payments for certain maternity services, as outlined in Contract Appendix B, Capitation Rates.

7.6.5 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. BMS 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 BMS' notification of any changes in the FFS Medicaid schedule.

7.6.6 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. Each MCO shall fully participate in and faithfully execute all directed payment programs established by BMS. These directed payment programs will be defined by BMS.

BMS will establish criteria for each directed payment program, including but not limited to the time frame for the directed payment; providers who will participate in the directed payment; and the mechanism for the calculation and delivery of the amount(s) to be paid to the selected providers. MCOs will collect and provide to BMS such information as is required to support all directed payment programs.

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.

DPPs are established in accordance with CMS requirements, including:

- In accordance with 42 CFR §438.6(c)(2)(i)(C), BMS 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), BMS must assure that all expenditures for this payment arrangement are developed in accordance with 42 CFR §438.4, the

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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 depending on the approved DPP by CMS.

No DPP funds will be applied to the maternity kick payments. Directed payments are required to be made via electronic fund transfer (EFT) unless requested in another form by the qualifying provider.

7.6.6.1 Directed Payments Reporting

1. BMS will send each MCO a report along with its quarterly payment that indicates the amount of the total payment for each Qualified Provider.

2. BMS 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 BMS, 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.

7.6.6.2 Directed Payments Adjustment

The MCO is prohibited from making any changes to the DPP reimbursement levels unless at the direction of BMS.

No retroactive adjustments to the Directed Payments may be issued by the MCO to the Qualified Providers unless such retroactive adjustment was approved by BMS. BMS may treat such retroactive adjustments to a claim as a violation of Article III, Section 2.7, Timely Payment Requirement.

7.6.7 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.

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Per 42 CFR §438.6(e), the MCO must 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 BMS 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 16th and last day 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.

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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.

The provisions of this section, Article III, Section 7.6.7 became effective January 1, 2019.

7.7 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 BMS for the services, or if the provider, under Contract or other arrangement with the MCO, fails to receive payment from BMS 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.

A preferred provider may not balance bill enrollees for covered services. More specifically, a preferred provider cannot bill for the difference between the provider's charge and the allowed amount. Providers must be in compliance with Section 1902(n)(3)(B) of the Social Security Act, and Section 1417 of the Balanced Budget Act of 1997.

7.8 Managed Care Premium Tax

Pursuant to 42 CFR §438.5(e), the premium tax will be part of the non-benefit component of the capitation rates, and, as such, the cost of the tax on the MCO will be inclusive in the PMPM capitation rates paid to the MCO in accordance with the tax levied under West Virginia Code §11-27-10a.

BMS will perform the semi-annualend year reconciliation (based on data submitted from January 1 - June 30th and July 1 - December 31) of the premium tax amounts at the MCO level as compared to the premium tax component included in the PMPM. Once each MCO's semi-annual premium tax amount is known, the State will reconcile that to the amount paid through the capitation payments. If the amount paid is less than the premium tax amount, an increase will be made to future capitation payments. If the amount paid is greater than the premium tax amount, a decrease will be made to future capitation amounts.

8. FRAUD, WASTE, AND ABUSE (FWA) REQUIREMENTS

8.1 Fraud, Waste, and Abuse Guidelines

8.1.1 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 BMS by October 1st each year. The compliance plan must include policies and procedures to prevent, detect, investigate, and report potential

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FWA as outlined by BMS. 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.

8.1.2 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 BMS, the Medicaid Fraud Control Unit (MFCU), the Office of the Inspector General (OIG) and the Centers for Medicare and Medicaid Services (CMS) 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 BMS, 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.

8.1.2.1 Program Integrity Staffing Requirements

The MCO must have at least the equivalent of one (1) full-time, West Virginia-based Program Integrity Professional per 60,000 or fewer enrollees 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 BMS.
3. Execute and respond to requests for information (RFIs) from the MFCU, including MFCU data requests.
4. Execute and respond to RFIs from BMS, 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 BMS 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.

8.1.2.2 Program Integrity Points of Contact

The MCO must designate one (1) primary and one (1) secondary contact person for all BMS Program Integrity and MFCU requests for data, records, or other information. BMS 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 BMS or MFCU staff enrollee within fourteen (14) calendar days or

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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.

8.1.3 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.

8.1.3.1 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.

8.1.3.2 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;

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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 BMS; and
8. Developing procedures to monitor service patterns of providers, Subcontractors, and beneficiaries.

8.1.3.3 Training of Senior Management, Employees, and Subcontractors

The MCOs and it 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.

8.1.3.4 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 must include, but is not limited to the following:

1. Identifying provider FWA by reviewing for:
    a. Patterns of self referral;
    b. Improper coding (upcoding and unbundling);
    c. Billing for services never rendered;
    d. Billing non-covered services as covered services;
    e. Unqualified providers billing for services; or
    f. 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 BMS by June 15th of each year.

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The MCO must have procedures in place for prompt notification to BMS 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 BMS 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.

8.1.4 Fraud, Waste, and Abuse Reports

The MCO must submit a report to BMS 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 BMS 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 BMS/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 BMS by the 15th 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 2.1.4 and Appendix D. See also Article III, Section 8.2, and Credible Allegation of Fraud.

The MCO will notify BMS of all incidents of suspected Medicaid fraud, waste, or abuse even if it is also referred to an entity other than BMS, such as the appropriate licensing and/or disciplinary bodies or other appropriate authorities.

8.1.5 Investigations

The MCO must cooperate and assist BMS 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, waste, or abuse has occurred in the Medicaid program, based on information, data, or facts, the MCO must immediately notify the BMS OPI following the completion of ordinary due diligence regarding a suspected fraud or abuse case. If BMS OPI accepts the case for State investigation, the MCO may not engage in investigation efforts other than coordination efforts with the State. The BMS OPI must supply a notice to the MCO notifying it of the case acceptance status no later than the tenth business day after the MCO notifies the BMS 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 BMS OPI and/or the MFCU indicating that the MCO is authorized to proceed with a case. Notification that

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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.

8.1.6 Prevention and Detection

The MCO must regularly submit encounter data as requested by BMS, as well as other data specified in Article III, Section 5.10 of this contract. All other terms and conditions of the original Purchase of Service Contract will remain unchanged and in full force and effect.

8.1.7 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 the False Claims Act and other laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.

8.2 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.

8.2.1 Provider Payment Suspension

The MCO is required to cooperate with BMS when payment suspensions are imposed on the Medicaid provider by BMS. When BMS 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 BMS by the MCO, the MCO must respond to the notice within three (3) business days and inform BMS of whether the MCO has implemented the suspension.

The MCO must also report all of the following information to BMS 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 BMS. 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 BMS. If the MCO does not suspend payments to the provider, BMS may impose contractual remedies.

BMS 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

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report the following information to BMS 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.

8.3 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, BMS reserves the right to identify, recover, and retain said overpayments. BMS will afford the MCO a reasonable grace period, as determined by BMS, to identify and recover overpayments from MCO providers before BMS will seek to recover and retain said overpayments.

BMS 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 8.1 of the Contract and BMS' Notice of Program Integrity Activities will be utilized as deconfliction tools. Deconfliction will occur regardless of the grace period determined by BMS.

8.3.1 BMS' Right to Collect from MCO

BMS shall have the right to recover provider overpayments, including those overpayments due to FWA, from the MCO if:

1. BMS or its contractor identifies an overpayment made by the MCO to the provider;
2. the payment occurred outside the grace period, as defined by BMS;
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.

BMS 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 BMS, 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 BMS within sixty (60) calendar days of the final decision.

8.3.2 BMS' Right to Collect from Providers

BMS has the right to recover provider overpayments, including those overpayments due to FWA, from the provider if:

1. BMS or its contractor identifies an overpayment made by the MCO to the provider;
2. the payment occurred outside the grace period, as defined by BMS;

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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. BMS, in its sole discretion, determines it is unable to collect from the MCO.

BMS 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 BMS chooses to exercise its right to collect the overpayment directly from a provider, the MCO assigns to BMS any rights it has to collect overpayments from the provider. Such payments recovered will be retained by BMS. 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 BMS collecting an overpayment directly from the provider are outlined in the BMS Policy Manual, chapter 800(B).

8.3.3 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 MCO 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) BMS has not duplicated this recovery, consistent with this section;

(c) the MCO followed proper procedures regarding fraud and/or abuse referrals to BMS;

(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 BMS and the imposition of liquidated damages as described in Appendix F.

If an overpayment has been referred by the MCO to BMS, 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 BMS, BMS may collect and retain the monies.

If BMS 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 BMS has partially completed an audit or investigation, and, in its sole discretion, BMS refers that information to the MCO for further investigation and recovery, BMS and MCO may

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negotiate a percentage division of any recoveries to be split by BMS and the MCO, on a case-by-case basis. BMS reserves the right to resume the audit or investigation if no agreement as to percentage division of any recovery can be agreed upon. If BMS, or an entity contracting with BMS, performs the entire investigation leading to identification of the overpayment, thereby giving it the right to keep one hundred percent (100%) of the overpayment, BMS, in its sole discretion, may opt to divide the recoveries with the MCO in an amount determined by BMS.

Pursuant to 42 CFR §438.608(d)(1), Article III, Section 8.3 does not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations.

8.3.4 MCO's Opportunity to Participate in Fraud Recoveries

The MCO shall submit fraud and abuse referrals to BMS using the prescribed form. Referral information submitted to BMS 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 shall 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.

8.3.5 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.

8.3.6 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.

9. MHT DENTAL SERVICES

9.1 MHT Children's Dental Services Administration and Covered Services [16]

The MCO must provide MHT 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.

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[16] The MCO must cover WVHB enrollees under 21 for the full scope of the dental services under the EPSDT coverage requirements.

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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.

9.2 MHT Adult Dental Services Administration and Covered Services

The MCO must provide enrollees twenty-one (21) years of age and older with diagnostics, preventive, and restorative dental services, excluding cosmetic services, limited to a $1,000 per enrollee per calendar year as specified in WV Policy- Chapter 505 Oral Health Services. The MCO must place appropriate prior authorization limits on all covered adult dental services 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. Covered adult dental services will require authorization prior to services being rendered and have a coverage limit of $1,000 per calendar year. MCO must develop and submit their policy and procedures for dental services to BMS for prior approval.

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 adult 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.

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.

Enrollees are responsible for payment of service cost exceeding the $1,000 yearly limit as specified in WV Policy- Chapter 505 Oral Health Services. Before providing dental services to a enrollee, providers must first furnish the enrollee with a document to be signed in advance of the service, stating that the enrollee understands that dental services exceeding the $1,000 yearly limit will be the responsibility of the enrollee. Services classified as cosmetic in nature are not covered for adults over the age of 21.

9.3 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 and in Article II, Section 5.10.1 (Key Staff Requirements), 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.

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9.4 Oral Health Fluoride Varnish Program

The MCO must educate its network providers about the BMS Infant and Child Oral Health Fluoride Varnish Program for Primary Care Practitioners, where primary care providers 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.

9.5 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, 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 1.2, 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.

9.6 Continuity of Care for MCO Orthodontic Services

The MCO's reimbursement for children's orthodontic services must cover the entire duration of treatment.

9.7 Continued Care for Active Orthodontia

The MCO must ensure, in conjunction with BMS, continuity of care for active orthodontia cases from January 1, 2014, 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.

10. BEHAVIORAL HEALTH SERVICES

10.1 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.[17] The benefit must be provided in accordance with 42 CFR part §438 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 BMS annually by June 30th. 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.

[17] 42 CFR § 438.210

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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 must not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of any type applied to substantially all medical/surgical benefits in the same classification furnished to enrollees, to maintain compliance with the Bureau's Mental Health Parity Plan.

If an MCO enrollee is provided mental health or substance use disorder benefits in any classification of benefits (inpatient, outpatient, emergency care or prescription drugs), mental health or substance use disorder benefits must be provided to the MCO enrollee in every classification in which medical/surgical benefits are provided.

The MCO may not impose quantitative or non-quantitative treatment limits (QTL/NQTLs) for mental health or substance use disorder benefits in any classification unless, under the policies and procedures of the MCO as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the QTL/NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification.

The MCO may cover, in addition to services covered under the Medicaid State Plan, any service necessary for complinace with the requirements for parity in mental health and substance use disorder benefits in 42 CFR §457.496.

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 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 when the child enters DHHR Youth Services, the child welfare system, or the juvenile justice system; or when the child or family requests mental health services or that a screen be conducted.. Providers must incorporate the EPSDT HealthCheck screening questions into their mental health screening process as a critical means for determining trauma history and any current trauma-related symptoms. 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 E.

In addition, the MCO shall provide a quarterly report of the average wait time to access mental health services from the date of referral by a primary care or other referring provider, to the time the youth is seen by a mental health care professional.

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10.2 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 in accordance with Article II, Section 5.10.1 (Key Staff Requirements). 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.

10.3 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, and psychiatric residential treatment services. The MCO must follow BMS FFS policies specific to the drug testing limit requirements contained in Chapter 529 of the WV Medicaid Provider Manual for drug screening services. The MCO may implement its own prior authorization requirements for these services.

10.4 Services Not Covered under Managed Care

The MCO is not responsible for payment for the following behavioral health services:

- Services provided to individuals under age twenty-one (21) performed in a Children's Residential Facility[18]

10.5 Coordination of Care

Notwithstanding internal care coordination of care requirements outlined in Article III, Section 5.3 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.

10.6 Adult Inpatient and Residential Care for Behavioral Health

Article III, Section 7.6.1, 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;

[18] The State Hospitals are considered IMD facilities.

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- 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 a 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 10.6, the MCO is responsible for any claims incurred during involuntary inpatient facility stay.

10.7 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 a 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.

10.8 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, subject to Article III, Section 10.8.1 below, the MCO must comply with the court order and pay for the services.

10.8.1 Medical Necessity for Court Ordered Services

If the MCO determines that the court ordered payment of services should not be paid due to the services:

- not meeting medical necessity criteria;
- not being West Virginia Medicaid covered services, or
- for any other reason,

the MCO must, within two (2) business days of receipt of the court order, contact BMS to review the case and explain the MCO's objections to the order. This review request must be made and

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approved by BMS before making any denial of services to the enrollee that would be contrary to the court order.

BMS will review MCO's request for non-coverage of court ordered services and, in its sole discretion, determine whether the benefits should be paid. If BMS determines the benefits are payable under the court order, the MCO will pay them consistent with Article III, Section 10.8 above. The MCO shall be required to honor the authorization within seven (7) calendar days notice of the decision by BMS.

IMD services are exempted from this section of the contract and the policy as defined by Article III, Section 7.6.7 of the contract shall be adhered to for these services.

10.9 Behavioral Health Provider Network

The MCO must comply with this Section notwithstanding Article III, Section 2 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. BMS 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 BMS' notification of any changes in the FFS Medicaid schedule.

Partial hospitalization programs must be approved by BMS before the MCO may offer the services to its enrollees by that provider.

10.10 Behavioral Health Service Authorization

In addition to the service authorization requirements outlined in Article III, Section 5.4, the MCO must utilize BMS' standard behavioral service authorization format or other authorization format approved by the contracted provider. 10.11 Substance Use Disorder (SUD) Services

10.11.1 General Requirements

In response to the opioid epidemic in West Virginia, BMS seeks to enhance available SUD prevention and treatment services available to Medicaid enrollees.

10.11.2 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;

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- 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.

BMS 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.

10.11.3 SUD Services Coninuum 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 BMS regarding SUD services as outlined in the West Virginia Medicaid Provider Manual, Chapter 504: Substance Use Disorder Services. The MCO must make all reasonable efforts to contract with all SUD service providers.

10.11.3.1 Medicaid State Plan SUD Services

Medicaid State Plan SUD services include:

- Targeted Case Management;
- Naloxone Administration Services (non-covered MCO service);
- 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).

10.11.3.2 SUD 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);

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- 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 enrollees during the admission and discharge transition process for Opioid Treatment Program services.

10.11.3.3 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. BMS-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.

10.11.3.4 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 BMS 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.

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- 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 (l) 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.

10.11.4 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.

10.11.5 SUD Provider Certification, Credentialing, and Network

BMS' Administrative Services Organization (ASO) contractor will complete the SUD provider certification process and provide a report to BMS. Final certification letters will be sent out by BMS and the MCO will be notified of the certified providers by BMS.

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 I.

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10.11.6 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. As part of BMS' 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 MCO 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.

10.11.7 SUD Reporting Requirements

The MCO must follow all monitoring and evaluation requirements of the SUD Waiver.

11. DELEGATION

In accordance with 42 CFR §438.230, 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.

12. Emergency and Disaster Declaration

The MCO in good faith will fully execute any addendum, and adhere to any memorandum, directive, order, reporting requirement or other publication by BMS setting forth necessary measures implemented by BMS related to any State, federal or local emergency in order to ensure that:

- The Medicaid program continues to operate efficiently;
- Covered services are delivered to enrollees in a timely and effective manner;
- Providers receive funds needed to continue to operate and provide needed services to enrollees (assuming the funding is supported by proper legal authority); and
- All other public health concerns related to such emergency which can be addressed by Medicaid in cooperation with the MCOs in a manner consistent with State, federal and local laws are sufficiently addressed.

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APPENDIX A: DESCRIPTION OF MCO COVERED AND EXCLUDED SERVICES

The following charts present an explanation of the medical, behavioral, and dental services which the MCO is required to provide; however, the Medicaid State Plan and policy is the final source for defining these services. The MCO should refer to the FFS Medicaid provider manuals available on the WV 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 these services. Please note that these charts, which list the definitions of services provided under the FFS Medicaid program, are provided as a reference for the MCO. The MCO is responsible for determining whether services are Medically Necessary and whether the MCO will require prior approval for services.

Medicaid benefit packages differ depending on whether the beneficiary is covered under MHT, WVHB managed care or FFS programs. The following charts present the covered services under each of these benefit packages.

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MCO Covered Services for Mountain Health Trust

MHT 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.	

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MHT MEDICAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
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).
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.

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MHT MEDICAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Handicapped Children's Services/ Children 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 enrollees' 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, corneal transplants, and long-term acute care (LTAC)	Excludes those adults in institutions for mental diseases (IMDs). 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.

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MHT MEDICAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Inpatient Rehabilitation	Services related to inpatient facilities that provide rehabilitation services for Medicaid eligible individuals.	Services that are medical inpatient rehabilitation services for Medicaid eligible individuals, and general medical outpatient services which meet certification requirements of the Office of Facility, Licensure and Certification.	
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 SUD.	Must be ordered by physician. Certain procedures may have service limits.
Nurse Practitioners' Services	Services provided by a nurse midwife, nurse anesthetist, family, or pediatric nurse practitioner.	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 SUD, 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 sublucations of the foot are not covered.

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MHT MEDICAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Private Duty Nursing (PDN)	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-hour nursing care if Medically Necessary.	Prior approval may be required. Limited to children under twenty-one (21) years of age.
Prosthetic Devices and Durable Medical Equipment (DME)	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 DME 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 (RFTS)	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, and nurse practitioner providing primary care in a clinic setting.	Physician, physician assistant, nurse practitioner, 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.	

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MHT MEDICAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
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 (under twenty-one (21) -exam, treatment services, lenses, frames, and needed repairs.	Adults limited to medical treatment only. Prescription sunglasses and designer frames are excluded. For adults, eyeglasses are limited to the first pair after cataract surgery. Contact lenses for adults and children covered for certain diagnosis.

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MCO Covered Dental Services for Mountain Health Trust

MHT DENTAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Dental Services (Adult)	Services provided by a dentist, orthodontist, or oral surgeon.	1) Emergency procedures to treat fractures, reduce pain, or eliminate infection and; 2) Diagnostic, preventive, and restorative services.	Adult coverage limited to $1,000 per calendar year. Services classified as cosmetic are not covered.
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).

MCO Covered Behavioral Services for Mountain Health Trust *

MHT BEHAVIORAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Behavioral Health Rehabilitation for Individuals Under Age twenty-one (21), Psychiatric Residential Treatment Facility (PRTF)	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 SUD.	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 (MAT), and other program services for individuals with mental illness, IDD and SUD.	Procedure specific limits on frequency and units. Only assertive community treatment (ACT) providers certified by BMS or the Bureau of Behavioral Health and Health Facilities may provide ACT services. Excludes children's residential treatment.
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.

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MHT BEHAVIORAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Hospital Services, Inpatient – Behavioral Health and Substance Use Stays	Inpatient hospital services related to the treatment of mental disorders or SUD.	Inpatient hospital services related to the diagnosis, evaluation, and treatment of behavioral health or SUD.	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.
Inpatient Psychiatric Services for Individuals Age twenty-one (21) to sixty-four (64)	Inpatient psychiatric facility services furnished at an Institution for mental diseases (IMD)	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.	May cover institutions for mental diseases (IMD) stays for enrollees aged twenty-one to sixty-four (21-64) as "in lieu of services" for up to fifteen (15) days during a calendar month.
Drug Screening	Laboratory service to screen for presence of one (1) or more drugs of use.	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) 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 10.11	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 a MCO covered benefit.

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MCO Covered Services for West Virginia Health Bridge

WVHB 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.	
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.	

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WVHB MEDICAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Family Planning Services & Supplies	Services to aid enrollees of child-bearing 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.
Children with Disabilities Services/ Children with Special Health Care Needs Services	Specialty services provided to children with disabilities and those who may be at risk of disabling conditions.	Specialty medical care, diagnosis, and treatment.	Services are provided to individuals 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 enrollees' 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, corneal transplants, and long-term acute care (LTAC).	Excludes those adults in institutions for mental diseases (IMDs). 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.

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WVHB MEDICAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
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.	Services that are medical inpatient rehabilitation services for Medicaid eligible individuals, and general medical outpatient services which meet certification requirements of the Office of Facility, Licensure and Certification.	
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 SUD.	Must be ordered by physician. Certain procedures may have service limits.
Nurse Practitioners' Services	Services provided by a nurse midwife, nurse anesthetist, family, or pediatric nurse practitioner.	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. Certain procedures may have service limits, or require prior authorization.
Physician Services	Services of a physician to a 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 SUD, and fluoride varnish services. Physician services may be delivered using telehealth.	Certain procedures may have service limits, or require prior authorization. Fluoride varnish services are not available for adults.
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 sublucations of the foot are not covered.

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WVHB MEDICAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Private Duty Nursing (PDN)	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.
Prosthetic Devices and Durable Medical Equipment (DME)	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 DME 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 (RFTS)	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) to sixty (60) days postpartum and infants less than one year of age. No prior authorizations can be required for RFTS services.
Rural Health Clinic (RHC) Services: Including Federally Qualified Health Centers (FQHC)	Physician, physician assistant, and nurse practitioner providing primary care in a clinic setting.	Physician, physician assistant, nurse practitioner, 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, under twenty-one (21), 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.

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WVHB MEDICAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
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, under twenty-one (21), exam, treatment services, lenses, frames, and needed repairs.	Adults limited to medical treatment only for vision services. Prescription sunglasses and designer frames are excluded. For Adults, eyeglasses are limited to the first pair after cataract surgery. Contact lenses for adults and children covered for certain diagnosis.

MCO Covered Dental Services for West Virginia Health Bridge

WVHB DENTAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Dental Services [19]	Services provided by a dentist, orthodontist, or oral surgeon.	1) Emergency procedures to treat fractures, reduce pain, or eliminate infection and; 2) Diagnostic, preventive, and restorative services.	Adult coverage limited to $1,000 per calendar year. Services classified as cosmetic are not covered.

MCO Covered Behavioral Services for West Virginia Health Bridge *

WVHB BEHAVIORAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Behavioral Health Rehabilitation for Individuals Under Age twenty-one (21); Psychiatric Residential Treatment	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 SUD.	Procedure specific limits on frequency and units.

[19] The MCO must cover WVHB enrollees under twenty-one (21) for the full scope of the dental services under the EPSDT coverage requirements.

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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 SUD.	Procedure specific limits on frequency and units. Only assertive community treatment (ACT) providers certified by BMS or the Bureau of Behavioral Health and Health Facilities may provide ACT services. Excludes children's residential treatment.
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.
Inpatient Psychiatric Services for Individuals Age twenty-one (21) to sixty-four (64)	Inpatient psychiatric facility services furnished at an Institution for mental diseases (IMD)	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.	May cover institutions for mental diseases (IMD) stays for enrollees aged twenty-one to sixty-four (21-64) as "in lieu of services" for up to fifteen (15) days during a calendar month.
Hospital Services, Inpatient – Behavioral Health and SUD Stays	Inpatient hospital services related to the treatment of mental disorders or SUD.	Inpatient hospital services related to the diagnosis, evaluation, and treatment of behavioral health or SUD.	NA
Drug Screening	Laboratory service to screen for presence of one or more drugs of use.	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) 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 10.11	Opioid Treatment Program services included in the SUD waiver will be provided through Medicaid FFS.

*An outpatient follow-up session immediately following the discharge from the facility is a covered MCO benefit.

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The MCO is not required to provide weight management services for both MHT and WVHB; the MCO may provide these services as a Value-Added Service except for bariatric surgery which is a covered benefit under the State Plan.

Medicaid Benefits Covered Under Fee-For-Service (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.

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 (3) years and under through the Birth to Three program.	Services provided by enrolled Birth to Three (3) providers.	
Intermediate Care Facility for the Mentally Retarded (ICF/MR)	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) 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.

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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 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 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.

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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.
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. Prior authorization by BMS may be required for non-emergency ambulance transportation.
Tubal Ligation	Family planning service provided to individuals of childbearing age to permanently prevent pregnancy.	In accordance with Senate Bill 716, the Department of Health and Human Resources shall make payment for tubal ligation without requiring at least 30 days between the date of informed consent and the date of the tubal ligation procedure.	Any licensed doctor providing these services must be compliant with the Federal Social Security Act 42 CFR §441, Subpart F – Sterilizations, §441.255 and §441.256 requirements, which requires informed consent and medical necessity.
Opioid Treatment Program services under the Substance Use Disorder (SUD) Services 1115 waiver	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	Comprehensive opioid MAT program including medication, treatment services and laboratory services.	Must be provided in a BMS-licensed methadone clinic and in accordance with ASAM® criteria.

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Abortion Services

Under the terms of this Contract, MCO may not reimburse Medicaid providers for the services provided to Mountain Health Trust or West Virginia Health Bridge enrollees under any reported and verified abortion CPT codes. Abortion Services will be reimbursed under FFS Medicaid.

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MR/DD and Aged/Disabled Waivers

The following services are excluded from the MCO's capitation rates and will be provided under separate waivers:

MEDICAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Aged/Disabled Waiver	Community based services for aged/disabled as an alternative to nursing facility care.	Nursing care, transportation, and homemaker services.	May not be provided in a hospital, nursing facility, or ICF/MR. Cost of service must be less than nursing facility care.
MR/DD Waiver	Community based services for mentally retarded/developmentally disabled individuals as an alternative to ICF/MR level of care.	Day and residential habilitation (aggressive active treatment), respite, transportation, and case management.	May not be provided in a hospital, nursing facility, or ICF/MR. Cost of service must be less than nursing facility care.

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APPENDIX B: OVERVIEW OF WEST VIRGINIA'S SFY 2022 MOUNTAIN HEALTH TRUST AND WEST VIRGINIA HEALTH BRIDGE PAYMENT METHODOLOGY AND CAPITATION RATES

(under a separate cover)

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APPENDIX C: MARKETING AND MEMBER MATERIALS POLICIES

Legal Authorities

MCO marketing materials, and all member other materials used by the MCO under the MCO Contract must comply with the requirements of Federal law, including but not limited to 42 U.S.C §1396u-2, and 42 CFR §438.104. Additionally, such materials must also comply with terms of the MCO Contract, including but not limited to any appendices, supplements, or written guidance issued by BMS and/or its agent(s), collectively known as the Marketing and Member Materials Policies.

The Marketing and Member Materials Policies contained in this MCO Contract, and in any appendices, supplements, and/or written guidance may be amended by BMS at any time. The MCO will be notified of any such amendments or changes in writing.

All Marketing and Member Materials Policies are applicable to the MCO, its agents, subcontractors, providers, and any individual, organization, or entity connected to the MCOs marketing or enrollee communications activities, whether paid or unpaid (e.g., volunteers).

MCO Marketing Plan and Material Submissions

The MCO must submit a Marketing Plan to BMS annually for review and prior written approval. BMS will review and approve the Marketing Plan and all attached marketing materials within forty-five (45) calendar days.

Any marketing or other MCO materials submitted for BMS approval will be reviewed within forty-five (45) calendar days of submission. As soon as possible after submission, BMS will issue a written review decision to the MCO. The MCO agrees to only engage in marketing activities and only use materials that are pre-approved in writing by BMS.

General enrollee health education brochures and enrollee health education materials do not require approval from BMS.

General Materials Policies

MCO marketing and member materials used by the MCO must meet the requirements below.

A. Clarity of the Material's Purpose

To meet the clarity of purpose requirement, all MCO materials, including telephonic scripts, text messages, voice-messages, and other digital communications, must be written, structured, or designed so that the purpose of the material is clear and immediately evident to the intended audience. The MCO should use descriptive headings and conspicuous fonts in written materials, and should promptly state the purpose of telephone calls when communicating by telephone or leaving voice-messages. The MCO must include appropriate contact information for the MCO whereby the public or a current enrollee may inquire about the material's content.

B. Readability of the Material

To meet the readability requirement, all MCO materials must have an appropriate format and reading grade level.

Regarding format, all MCO written materials (in paper and electronic format) must use a conspicuously visible font size (12-point font or larger), and whenever practicable, include

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descriptive or summary text headings to ensure meaningful access for those limited by low-English proficiency and those limited by low-reading proficiency.

Regarding reading level, all MCO materials must be written at or below a sixth-grade level (Grade 6 or below). The MCO must measure the reading level of its materials using an assessment tool or software program which is common to the industry and produces a verifiable score report that the MCO will retain for its records. Any material submitted for BMS approval must contain a statement from the MCO certifying that the material complies with the reading level standard set forth herein, unless an exemption has been authorized by BMS.

C. Translation and Accessibility Resources

To meet the translation and accessibility resource requirement, all MCO materials must provide, either as part of the material or via a enclosure, instructions for obtaining the material in an alternate language, or through auxiliary aids and services like sign language communication, oral interpretation, oral translation, and any additional accessibility resources offered by the MCO.

D. Social Determinants of Health Resources

If applicable, MCO materials must inform the intended audience how they may access community-based resources to assist with SDOH needs.

E. Privacy Protections

All MCO materials transmitted in printed form must be packaged in a manner that conceals the content of the MCO communication from public view. This standard applies to letters, notices, postcards, flyers, mailers, manuals, booklets, and non-traditional printed materials. Additionally, the outside of material packaging must not contain information or text that identifies the addressee as a Medicaid recipient.

Marketing Policies

The MCO may conduct general advertising that does not specifically solicit the Medicaid population for enrollment. BMS will conduct MCO enrollment process in accordance with 42 CFR §438.54. BMS, either directly or through its designee, will process all enrollments into the MCO.

A. 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 content of all MCO marketing materials—whether taking written, printed, digital, telephonic, or any other form, and regardless of transmission or distribution method, and regardless of authorship or creator—must be pre-approved in writing by BMS;
2. The content of MCO marketing materials must be culturally appropriate and accessible for all enrollees and potential enrollees;
3. The content of MCO marketing materials must be culturally appropriate and accessible for all enrollees and potential enrollees;
4. Terms such as “choose,” “pick,” “join,” etc. are allowed in marketing materials as long as the Enrollment Broker contractor’s telephone number is included;

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5. 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 BMS prior to distribution;
6. The MCO may only provide plan specific information via telephone 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 BMS prior to distribution;
7. The MCO may respond to direct questions from potential enrollees with accurate information during such telephone calls;
8. The MCO may survey their former and current enrollees;
9. The MCO may provide Gifts approved by BMS to encourage current enrollees to participate in the MCO surveys;
10. 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
11. At BMS' 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.

B. Prohibited Marketing Practices

A MCO engaging in the prohibited Marketing practices listed below will be in violation of the MCO Contract and, at a minimum, be subject to the remedies available under the MCO Contract. This list is not intended to be exhaustive and MCOs should ensure their marketing activities comply with all federal and state laws and regulations.

The following prohibitions are applicable to the MCO, its agents, Subcontractors, and MCO providers:

1. Distributing Marketing materials without prior BMS approval;
2. Distributing Marketing materials written above the 6th grade reading level, unless approved by BMS;
3. 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;
4. 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;
5. 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;

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6. 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;
7. Marketing in or around public assistance offices, including eligibility offices;
8. Direct Mail Marketing to potential enrollees.
9. Directly or indirectly, engaging in door-to-door, email, text, telephone, and other Cold Call Marketing activities;
10. Using spam (an unwanted, disruptive commercial message posted on a computer network or sent by email);
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. Using absolute superlatives (e.g., “the best,” “highest ranked,” “rated number 1”) unless they are substantiated with supporting data provided to BMS;
14. Portraying competitors in a negative manner;
15. Referencing the commercial component of the MCO in any Marketing materials;
16. Knowingly marketing to persons currently enrolled in another MCO directly by mail, phone, or electronic means of communication;
17. Influencing enrollment in conjunction with the sale or offering of any private insurance;
18. Tying enrollment in the Medicaid MCO with purchasing (or the provision of) other types of private insurance;
19. Charging enrollees for goods or services distributed at MCO or Medicaid events;
20. Charging enrollees a fee for accessing the MCO’s website;
21. Using marketing agents who are paid solely by commission;
22. Purchasing or otherwise acquiring mailing lists from third party vendors, or for paying BMS’ contractors or Subcontractors to send plan specific materials to potential enrollees;
23. Assisting with Medicaid MCO enrollment form;
24. Conducting potential enrollee orientation in common areas of providers’ offices;
25. Posting MCO-specific, non-health related materials or banners in provider offices;
26. 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*

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providers do immunizations, blood pressure checks, etc. as long as the provider is not soliciting enrollment or distributing plan specific MCO materials.);

27. Providing gifts to providers for the purpose of distributing them directly to the MCO's potential or current enrollees;
28. Offering gifts valued over $15 to potential enrollees;
29. Making potential enrollee gifts conditional based on enrollment with the MCO;
30. 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;

Social Media Marketing Practices

In addition to all marketing requirements outlined in the MCO Contract, the MCO must comply with the social media Marketing practices as outlined below.

The following lists are applicable to the MCO, its agents, Subcontractors, and MCO providers:

A. General Social Media Guidelines

1. At BMS' approval, the MCO may partake in forms of social media advertising (i.e. Twitter, Facebook, Instagram);
2. At BMS' approval, the MCO may purchase advertisement banners on social media outlets. The content of such advertisements must be approved by BMS prior to distribution;
3. The MCO may post MCO Medicaid events on social media sources. The content of such posts must be approved by BMS approval prior to posting;
4. The MCO may post general non-advertising information regarding MCO activities. The content of such posts does not require BMS' prior approval; and
5. Any enrollee complaints received through the social media sources must be processed and resolved through the general complaint intake system.

B. 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: Instagram, Twitter, Teams, Zoom, 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;

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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. MCO Events and In-Person Marketing

If the MCO, its agents, Subcontractors, MCO providers, or any individual, organization, or entity connected to the MCO, whether paid or unpaid (i.e. volunteers), engages in or participates in-person at an event, either physically or by digital communication technologies (i.e. Zoom or other video conferencing methods) on behalf of the MCO, the MCO must ensure that the participant's conduct is not solicitous of enrollment and that any MCO materials distributed by or through the participant at such an event comply with the Marketing and Member Materials Policies contained in the MCO Contract

D. Marketing Representative Training

The MCO is required to inform any agents, subcontractors, providers, and/or any individual, organization, or entity connected to the MCO, whether paid or unpaid, of these Marketing and Member Material Policies prior to such person's participation in any event or in-person marketing activity on behalf of the MCO.

E. Event Handouts and Other MCO Materials

All materials used at MCO events or for in-person Marketing must meet the requirements list herein for similar marketing materials.

F. Gifts For 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 must 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.

G. Gifts for Current Enrollees

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. BMS must provide prior approval of all monetary and non-monetary compensation provided to enrollees in exchange for participating in any MCO activities.

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APPENDIX D: SUMMARY OF MHT AND WVHB MCO REPORTING REQUIREMENTS

All MCO reports submitted under this Contract must reflect MHT and WVHB program-related data only unless otherwise requested by BMS.

Reporting Requirement	Timeframe				
	Monthly	**Quarterly**	**Annually**	**Other**	**Due Date**
Quarterly Reporting					
MHT Quarterly Reporting Template TANF, Expansion, SSI-1: Enrollment and Membership Report TANF, Expansion, SSI-2: Provider Network Status Report TANF, Expansion, SSI-3: Claims Processing TANF-4, Expansion-4, SSI-4: Experience Summary TANF-5, Expansion-5, SSI-5: Lag Tables TANF-6, Expansion-6, SSI-6: Summary of Claims Paid Outside Encounter Data and Sub-Capitation Arrangements TANF, Expansion, SSI-7: Member and Provider Services Functions TANF, Expansion, SSI-8: Statement of Revenue and Expenses TANF, Expansion, SSI-9: Out-of-Network Utilization Report TANF, Expansion, SSI-10: Member Access to Care		X			Within forty-five (45) calendar days of end of quarter (by the 15th day of the second month following the end of the reporting period)
Quality Reporting					
Written Description of PIPs and Results			X		On or before July 15th
PIP Progress Report		X			Within one-hundred twenty (120) days of end of quarter
HEDIS			X		On or before June 15th (audited)
QAPI Annual Evaluation Report Including Status and Results			X		On or before June 15th
QAPI CAP				X	Within thirty (30) days of identification of systemic problem
CAHPS Enrollee Survey Analysis, Action Plan and Evaluation			X		Annual analysis is due on or before August 15th.

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Reporting Requirement	Timeframe				
	Monthly	**Quarterly**	**Annually**	**Other**	**Due Date**
Accreditation Review Report				X	Upon completion or change in status
Encounter Data	X				Within thirty (30) days of end of month
Adult and Child Core Quality Measures			X		On or before September 1st
Provider Reporting					
Provider Network Data	X				Electronic provider directories to be submitted to BMS' Enrollment Broker monthly
Provider Network Adequacy		X	X	X	• Full network - Annually by October 31st • All Network changes by specialty – Quarterly, 45 days after end of the quarter • PCP changes –fourteen (14) days after the change • Hospital changes – immediately • Material changes of other providers affecting service delivery- fourteen (14) days after the change
Provider Satisfaction Survey			X		By June 30th of each contract year.
Suspension and Adverse Enrollment Action Report (formerly the CAF Suspension and PDC reports)	X				By the 15th of the following month
Financial Reporting					
Annual Financial Statements			X		On or before June 1st
Offices of the Insurance Commissioner Reports – Quarterly and Annually		X	X		Concurrent with DOI submission
Third Party Liability Cases Not Pursued	X				The 15th of each month (to include all events from the prior month)

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Reporting Requirement	Timeframe				
	Monthly	**Quarterly**	**Annually**	**Other**	**Due Date**
Provider-Preventable Conditions			X		July 15th
PCP Payment Methodology				X	Upon request from BMS
Directed Payments Report		X			45 days after each quarter, providing payment has been received from BMS.
MHT and WVHB 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 15th of the month
IMD Report	X				Submit on the 15th and 30th of each month
Hospital Paid Claims Report		X			45 days after each quarter to OAMR
Federal Reporting					
Hysterectomies and Sterilizations			X		Submit attestation by October 1st
EPSDT Services and Reporting		X			45 days after each quarter
Other State Required Reporting					
Business Continuity Plan				X	Within ten (10) business days of BMS written request
Disaster Recovery Plan				X	Within ten (10) business days of BMS written request
Information Security Plan				X	Within ten (10) business days of BMS written request
System Quality Assurance Plan				X	Within ten (10) business days of BMS written request
Sexually Transmitted Diseases			X		Submit attestation by October 1st
Tuberculosis			X		Submit attestation by October 1st
Communicable Diseases			X		Submit attestation by October 1st
MCO Annual Report			X		On or before April 1st
Organization Chart			X		On or before October 1st
Marketing Plan			X		On or before October 1st
Care Coordination Program Description			X		On or before October 1st
Subcontractor Monitoring Plan				X	Within ten (10) business days of BMS written request
Data Accuracy and Completeness Plan			X		On or before October 1st
Activities Summary, Analyses, and Results of Provider/Beneficiary Utilization to Detect FWA			X		On or before June 15th
HB 4217 Report			X		On March 30th of each year

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Reporting Requirement	Timeframe				
	Monthly	**Quarterly**	**Annually**	**Other**	**Due Date**
Alternative Payment Model Report			X		August 15th
FWA Reporting	X				By the 15th of the following month
Disclosure of Ownership Reporting			X	X	• Annually, on or before July 1st; • Upon request, within thirty-five (35) calendar days; or • Upon change in ownership, within thirty-five (35) calendar days
FWA Internal Compliance Plan			X		On or before October 1st
Parity in Mental Health and Substance Use Disorder (SUD) Benefits Compliance Plan			X		On or before June 30th
Claims Aging Report	X				By the 15th of the following month
Mental Health Services Access Report		**X**			As defined in Article III, Section 10.1, the MCO shall provide a mental health service utilization report that provides data on the mental health services approved and denied by the MCO, as well as the average wait time between referral to mental health appointment.
SUD Utilization/Finance Report	**X**				By the 10th of the following month
PRTF and Children's Residential Services and Demographic Report	**X**				By the 15th day of the following month
Monthly Member Status Report	**X**				By the 15th day of the following month

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APPENDIX E 1: DATA CERTIFICATION FORM

STATE OF WEST VIRGINIA
MOUNTAIN HEALTH TRUST OR
WEST VIRGINIA HEALTH BRIDGE

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 (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)).

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APPENDIX E 2: DATA CERTIFICATION FOR MONTHLY AND WEEKLY ENCOUNTER DATA REPORT SUBMISSION

STATE OF WEST VIRGINIA
MOUNTAIN HEALTH TRUST OR
WEST VIRGINIA HEALTH BRIDGE

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)).

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APPENDIX F: SERVICE LEVEL AGREEMENTS (SLA) AND LIQUIDATED DAMAGES MATRIX

Mountain Health Trust and West Virginia Health Bridge

All areas of responsibility and all requirements in the Contract will be subject to performance evaluation by BMS. Any and all responsibilities or requirements not fulfilled may have remedies, and BMS 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 BMS. 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 4.12, 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 and 5.10.13.	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 3.8.	Quarterly	$1,000 for each percentage point below ninety-eight percent (98%) if the MCO fails to meet the standard.

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#	Program Non-Performance	Measurement Period	Liquidated Damages
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 3.4.	Ongoing	$250 per each incident per affected enrollee.
6	Failure to report timely to BMS significant network changes as described in Article III, Section 2.1, 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 2.1, 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 3.1, and Appendix C.	Ongoing	$1,000 per each incident of non-compliance.
9	Failure to pay clean claims within 30 calendar days as required in Article III, Section 2.7.	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 provide timely MCO covered services as described in Appendix A of this Contract when, in the determination of BMS, 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
11	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 5.4.	Quarterly	$250,000 for each quarter in which the threshold is not met

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#	Program Non-Performance	Measurement Period	Liquidated Damages
12	Failure to administer enrollee copayments, including charging excess copayments for covered services, as determined by BMS and outlined in Article III, Section 3.9.	Ongoing	$100 per each copay incident imposed in error
13	Failure to hold or improperly release funds subject to a credible allegation of fraud payment hold.	Ongoing	Amount held or released improperly
14	Failure to adhere to the prohibitions and requirements related to program integrity activities and the recovery of overpayments as outlined in Article III, Section 8.	Ongoing	$5,000 per occurrence, plus forfeiture of all related recovered overpayments.
15	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.
16	Failure to timley report violations in the access, use and disclosure of PHI or timely report a security incident. Violations must be reported within 60 calendar days and without resonable delay after discovery.	Ongoing	$500 per enrollee per occurrence, not to exceed $10,000,000.

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APPENDIX G: MEDICAL LOSS RATIO (MLR) REPORTING METHODOLOGY

Appendix G of this Contract outlines the requirements for the Medical Loss Ratio (MLR) reporting and for calculating any program rebate amount that may be due to BMS in the event the MCO does not meet the minimum eighty-five percent (85%) MLR standard as provided by Article III, Section 7.3 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 7.3 of this Contract. The MCO must complete and submit the MLR Financial Reports to BMS, using the following schedule:

1. As required by BMS during the rate-setting and supplemental data request process;
2. Annually, eight (8) months following the end of the State Fiscal Year 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 §438.8.

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 BMS 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. MLR reports must be conducted by external auditors utilizing an "agreed upon procedures" method of review (by the MCOs' auditors).

Calculating MLRs

The MCO must calculate its program MLR utilizing the following formula:

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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 (3) 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).

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;

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- 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 BMS.

Incurred medical claims and expenses may not inlcude:

- 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 BMS as MLR remittance;
- Amounts paid to network providers as pass-through payments; and
- Additional elements are required by BMS.

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.

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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.

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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;

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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 BMS, 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

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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 a 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 enrollees 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.

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  - 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:
  a. Three percent (3%) of earned premium; or
  b. 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.

Pursuant to 42 CFR §438.8(f)(1) and (3), the WV MCO premium tax described in Article III, Section 7.8 will be excluded from the denominator of the MCO's MLR.

Rebating Capitation Payments: 85% MLR Standard is Not Met

For each MLR reporting year, the MCO must provide a rebate to BMS if the MCO does not meet the eighty-five percent (85%) MLR standard requirement.

In accordance with Article III, Section 7.3, a combined MLR percentage of less than eighty-five percent (85%) must be one hundred percent (100%) reimbursable to the State. The MCO is responsible for a fifty percent (50%) share of any MLR less than eighty-eight percent (88%) but greater than eighty-five percent (85%).

The MCO rebate amounts will be assessed by BMS using the MLR calculations provided within the SFY MLR Report submitted to BMS by the MCO. The MLR rebate, if any, is due to BMS in full sixty (60) calendar days after BMS 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 BMS in writing as soon as administratively possible and prior to making any MLR rebate payments to BMS.

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APPENDIX H: ALTERNATIVE PAYMENT MODEL (APM) REPORTING TEMPLATE

NAME OF MCO
CONTACT INFORMATION
INITIATIVE(S) SELECTED (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 perfomance and quality requirements)
DESCRIPTION OF INITIATIVE(S) (Please include provider partners, size and scope of initiative, effect on quality and cost to date) *APMs must encompass ten percent (10%) of members enrolled during the State Fiscal Year, excluding maternity kick provider payments. BMS intends to increase this target in future years.
RATIONALE FOR INITIATIVE(S)
Which value based health care goals are supported by this initiative? Check Box(es) ☐ Improve Quality of Care ☐ Lower Costs ☐ Improve Population Health Further Explanation:

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PERFORMANCE MEASURES

(Each goal should be linked to one or more performance measures)

Measure	Goal Linked	Source

DESCRIPTION OF MONITORING ACTIVITIES

EVALUATION OF EFFECTIVENESS OF PREVIOUS CONTRACT YEAR

(Please provide performance reports)

SUMMARY

(Please describe lessons learned and any implemented changes)

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BARRIERS (Please describe any significant barriers faced and strategies developed to overcome these barriers)
PLANS FOR NEXT CONTRACT YEAR

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APPENDIX I: PROVIDER NETWORK STANDARDS

This appendix summarizes the network standards and methodology for MCOs serving MHT and WVHB enrollees. These standards represent experience in West Virginia and current practices, recent utilization, patterns of care, and take into account provider network standards in use by other state Medicaid programs. The intent of setting these standards is to ensure enrollees have adequate access to services.

General Network Requirements

In accordance with 42 CFR §438.68(b), 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. 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 **(1) provider** for every five hundred (**500) enrollees** per county	One **(1) provider** for every two hundred fifty (**250) enrollees** per county
OB/GYN or certified nurse midwife	One **(1) provider** for every one thousand **(1,000) enrollees** per county	

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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)** providers within twenty **(20) miles** or thirty **(30) minutes** travel time	Two **(2)** providers within twenty **(20) miles** or thirty **(30) minutes** travel time
	Audiology	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
	Cardiology	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
	Dermatology	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
	General Surgery	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
	Gastroenterology	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
	Neurology	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
	Occupational Therapy	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
	Oncology	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
	Ophthalmology	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
	Orthopedics	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
	Orthopedic Surgeon	Two **(2)** providers within twenty **(20) miles** or thirty	Two **(2)** providers within twenty **(20) miles** or thirty **(30) minutes**

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Provider Category	Provider Type	Adult Standard	Pediatric Standard
		(30) minutes travel time	travel time
	Otolaryngology / Otorhinolaryngology	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
	Physical Therapy	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
	Pulmonology	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
	Physical Medicine and Rehabilitation Specialist	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
	Speech Therapy	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
Other Specialist	Anesthesiology	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
	Chiropractic	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
	Dialysis	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
	Durable Medical Equipment (DME)	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
	Endocrinology	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
	Hematology	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
	Home Health Services	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
	Nephrology	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
	Neurosurgery	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
	Orthotics and Prosthetics	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
	Pathology	One **(1)** provider within twenty **(20) miles** or thirty	One **(1)** provider within twenty **(20) miles** or thirty **(30) minutes**

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Provider Category	Provider Type	Adult Standard	Pediatric Standard
		(30) minutes travel time	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	**Urban:** One **(1)** hospital within thirty **(30) miles** or forty-five **(45) minutes** travel time **Rural:** One **(1)** hospital within sixty **(60) miles** or ninety **(90) minutes** travel time	**Urban:** One **(1)** hospital within thirty **(30) miles** or forty-five **(45) minutes** travel time **Rural:** One **(1)** hospital within sixty **(60) miles** or ninety **(90) minutes** travel time
	Tertiary Hospital Services[20]	**Urban:** One **(1)** hospital within thirty **(30) miles** or forty-five **(45) minutes** travel time **Rural:** One **(1)** hospital within sixty **(60) miles** or ninety **(90) minutes** travel time	**Urban:** One **(1)** hospital within thirty **(30) miles** or forty-five **(45) minutes** travel time **Rural:** One **(1)** hospital within sixty **(60) miles** or ninety **(90) minutes** travel time

Hospitals with Tertiary Services

Hospital Name	Pediatric Medical / Surgical Unit	Obstetrics Unit	Neonatal Intensive Care Unit
Beckley ARH	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

[20] 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.

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Hospital Name	Pediatric Medical / Surgical Unit	Obstetrics Unit	Neonatal Intensive Care Unit
Cabell Huntington	YES	YES	YES
Camden-Clark Memorial	YES	YES	NO
Davis Memorial	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
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 and Adult 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.

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Provider Category	Provider Type	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.

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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	**Urban:** One **(1)** hospital within thirty **(30) miles** or forty-five **(45) minutes** travel time **Rural:** One **(1)** hospital within sixty **(60) miles** or ninety **(90) minutes** travel time	N/A

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Provider Category	Provider Type	Adult Standard	Pediatric Standard
	Behavioral Health Clinic	Contract with identified list: • Appalachian Community Health Center; • EastRidge Health Systems, Inc.; • FMRS Health Systems, Inc.; • Healthways, Inc.; • Logan-Mingo Area Mental Health, Inc.; • Northwood Health Systems, Inc.; • Potomac Highlands Mental Health Guild, Inc.; • Prestera Center for Mental Health Services; • Seneca Health Services, Inc.; • Southern Highlands; • United Summit Center, Inc.; • Valley Comprehensive Community Mental Health Center, Inc.; and • Westbrook Health Services, Inc.	Contract with identified list: • Appalachian Community Health Center; • EastRidge Health Systems, Inc.; • FMRS Health Systems, Inc.; • Healthways, Inc.; • Logan-Mingo Area Mental Health, Inc.; • Northwood Health Systems, Inc.; • Potomac Highlands Mental Health Guild, Inc.; • Prestera Center for Mental Health Services; • Seneca Health Services, Inc.; • Southern Highlands; • United Summit Center, Inc.; • Valley Comprehensive Community Mental Health Center, Inc.; and • Westbrook Health Services, Inc.
	Psychiatric Residential Treatment Facility (PRTF)	N/A	Contract with identified list: • Highland Charleston; • River Park; and • Barboursville's School
SUD Provider	Outpatient SUD provider	One **(1)** provider within forty-five **(45) miles** or sixty **(60) minutes** travel time	One **(1)** provider within forty-five **(45) miles** or sixty **(60) minutes** travel time
SUD Facility	Residential SUD provider	One **(1)** provider within forty-five **(45) miles** or sixty **(60) minutes** travel time	One **(1)** provider within forty-five **(45) miles** or sixty **(60) minutes** travel time

Essential Community Providers (ECPs)

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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 **(1)** provider within forty-five **(45) miles** or sixty **(60) minutes** travel time	One **(1)** provider within forty-five **(45) miles** or sixty **(60) minutes** travel time

Network Adequacy for Additional Providers Types

BMS 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 **(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

Network Submission and Network Adequacy Evaluation

In accordance with the preceding standards, the MCOs must submit to BMS 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 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

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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 must follow each individual geographic data map. BMS will provide sample PDF and Excel formats for the geo maps and supporting data.

The geographic data maps (PDF) and supporting tables in Excel by county for each provider type for which there is a defined time or distance standard must be submitted to BMS annually, by October 31st.

Submission of Provider Network File

The MCO must submit to BMS annually by October 31st an Excel file listing all providers and facilities in the MCO's network for the Medicaid line of business only. Prior to submission, BMS will provide an Excel file template for the requested data. The files must 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, 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 BMS 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 BMS-provided template. The BMS-provided template contains instructions on which fields the MCO must populate. The MCO must submit the ratio worksheet to BMS annually by October 31st .

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Provider Network Evaluation

BMS 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, BMS will compare the number of the MCO's *unique providers* located within the county to the number of the MCO's MHT and WVHB enrollees within the county. BMS will calculate the number of MHT and WVHB enrollees using the greater of:

1) the MCO's actual number of MHT and WVHB enrollees in the county; or
2) the MCO's estimated number of MHT and WVHB enrollees based on the total number of all MHT and WVHB managed care enrollees within the county multiplied by the MCO's estimated market share as determined by the number of MCOs operating in the county (shown in the table below).

Number of Participating MCOs	Estimated MHT and WVHB Market Share
One (1) MCO	One hundred percent (100%)
Two (2) MCOs	Fifty percent (50%)
Three (3) MCOs	Thirty-three percent (33%)

To review compliance with time and travel distance standards, BMS will review geographic data maps and supporting tables to verify appropriate enrollee access to all provider types. BMS defines adequate access as ninety percent (90%) 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). BMS 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.

BMS or its contractor will assess the network against BMS' network requirements and provide an assessment of network adequacy to the MCO in a timely manner.

Exception Requests

BMS 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 BMS 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, as allowed in West Virginia's 1915(b) Waiver.