Physician Assured Access System
Provider Agreement

ARTICLE 1. INTRODUCTION

The West Virginia (WV) State Department of Health and Human Resources (DHHR), Bureau for Medical Services (BMS) is the single state agency administering the WV Medicaid Program. Pursuant to Title XIX of the Social Security Act, BMS is authorized by the Centers for Medicare and Medicaid Services (CMS) to implement a system of managed care for the WV Medicaid population. The State of WV operates a managed care program, known as the **Physician Assured Access System (PAAS),** a Primary Care Case Management (PCCM) program. The PAAS program is in effect in areas ineligible for fully integrated managed care delivery systems, as defined by the BMS.

1.1 Program Overview

The State of WV operates a Medicaid Program to provide health care for persons eligible under 1915(b)(1) waiver authority from the Federal government for a portion of its Medicaid population. In areas where fully integrated managed care delivery systems are not available, WV Medicaid operates a Primary Care Case Management program for PAAS eligible individuals. The program enrolls Medicaid members with primary care providers (PCPs) who provide, coordinate, and/or authorize all medically necessary services.

In exchange for a per member per month (PMPM) management fee, the PCP provides, or otherwise assures the delivery of, medically necessary primary care medical services and referrals for specialty services for an enrolled group of eligible individuals. The PCP assists the client in gaining access to the health care system and monitors the client's condition, health care needs, and service delivery.

Services that do not require a referral from the PCP include obstetrical/gynecological care, family planning services, most vision, hearing and dental services, behavioral health services, pharmacy services, and emergency room care.

Medicaid covered services delivered by the PCP are reimbursed at the Medicaid Fee-For-Service rate for the particular service rendered. To the extent services are provided or authorized by the PCP, the PAAS Program does not make Medicaid payments for services delivered outside the scope of coverage of the Medicaid program, thus a referral by the PCP does not guarantee payment.

The State's objectives include the following:

A. To improve access to medical care, including preventive services, primary care, and early prenatal care for WV's Medicaid population.

B. To ensure that every eligible Medicaid beneficiary is able to choose a primary care provider who will serve as his or her provider and be responsible for providing and coordinating medically necessary care.

1.2 Definitions

Some of the terms and definitions used by the State administered program are identified below. A more detailed list can be found in the Medicaid Provider Manual.

ACTION- the decision to deny or limit authorization or payment for health care services, including new authorizations and previously authorized services; failure to provide services in a timely manner.

ADVANCE DIRECTIVE - a document in which an individual gives instructions about their health care if, in the future, they cannot speak for themselves. An "agent" or "proxy" is given the power to make health care decisions (the kind of health care wanted/not wanted) for the individual.

AUTO-ASSIGNMENT – the process by which the BMS, or its designated entity, utilizes default assignment of a member to a PCP when a member does not select a PCP within a given time period, as defined by BMS.

BMS - the West Virginia Bureau for Medical Services (BMS).

CLIENT – *see* Member

CMS – Centers for Medicare and Medicaid Services (the agency formerly known as HCFA), a division of the federal Department of Health and Human Services.

COLD CALL MARKETING – any unsolicited personal contact with a potential enrollee by an employee or agent of a PCP for the purpose of influencing the individual to enroll with his/her practice. Cold call marketing methods include direct, indirect, door-to-door, or telephonic marketing enrollment practices.

CO-PAYMENT – any enrollment fee, premium, deductible, coinsurance, co-payment, or any other similar charge that imposes a cost-sharing requirement upon the recipient.

COST-BASED PAYMENT METHOD – a system of payment for health care, whereby reimbursement is based on a percentage of cost.

COVERED POPULATIONS – include the following eligibility categories as it relates to this agreement:

- Children and related poverty level populations (TANF)
- Adults and related poverty level populations, including pregnant women (TANF)
- Blind and Disabled adults and children (voluntary enrollment)
- Foster care children (voluntary enrollment)

*Excludes those persons dually eligible for Medicaid and Medicare, or currently institutionalized, or served through a Home and Community Based Waiver.

DISCRIMINATION – the refusal to accept the assignment of a member, the failure to treat a member, or the dismissal of a member on the basis of the member's age, race, sex, physical or mental handicaps, or his/her type of illness or condition. Discrimination does not include the good-faith decision that a member's illness or condition would be better treated by another type of health care provider.

EMERGENCY MEDICAL CONDITION – a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected, by a prudent layperson, to result in:

- placing the health of the individual (or, with a pregnant woman, the health of her unborn child) in serious jeopardy, or
- serious impairment to any bodily functions; or
- serious dysfunction of any body organ or part.

- with respect to a pregnant woman who is having contractions inadequate time to effect a safe transfer to another hospital before delivery or transfer if it poses a threat to the health or safety of the woman or the unborn child.

EMERGENCY SERVICES – covered inpatient and outpatient hospital services that are furnished by a provider that is qualified to furnish these services under this title, and are needed to evaluate or stabilize an emergency medical condition.

ENROLLEE – as it relates to this agreement, a Medicaid recipient who is currently enrolled in a PCCM program.

EPSDT - Early and Periodic Screening, Diagnosis and Treatment - a program defined by federal regulations, which covers screening and diagnostic services for enrollees under the age of 21 to determine physical and developmental problems and to ascertain health care treatment and other measures to correct or ameliorate any defects and chronic conditions discovered. **HealthCheck** is the EPSDT program for the State of West Virginia.

EPSDT OUTREACH – actions taken that include, but are not limited to, a telephone call or printed information mailed to alert a member about the features of the EPSDT program, when a health care screening is indicated or missed, and the benefits of preventive health care.

FAMILY PLANNING SERVICES – defined as those services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy. These services include:

a) health education and counseling necessary to make informed choices and understand contraceptive methods;
b) limited history and physical examination, which may include a pap smear if performed according to the U.S. Preventive Services Task Force Guidelines;
c) laboratory tests if medically indicated as part of decision making process for choice of contraceptive methods;
d) diagnosis and treatment of sexually transmitted diseases (STDs), if medically indicated;
e) screening, testing, and counseling of at-risk individuals for human immunodeficiency virus (HIV) and referral for treatment;
f) follow-up care for complications associated with contraceptive methods issued by the family planning provider;
g) provision of contraceptive pills/devices/supplies;
h) tubal ligation;
i) vasectomies; and
j) pregnancy testing and counseling.

*Maternity services, hysterectomies, and pregnancy terminations are not considered family planning services.

FEE-FOR-SERVICE – compensation to a provider based on a fee schedule for each Medicaid compensable service delivered to a Medicaid eligible member.

FULL TIME EQUIVALENT (FTE) – forty- (40) hours of service per week delivered by one or more individual primary care providers as it relates to this agreement.

HCFA – Health Care Financing Administration, now known as CMS.

HEALTHCHECK (EPSDT) PROGRAM – the program to ensure that Medicaid-eligible children, ages 0 through 20 years receive a comprehensive range of preventive health care services.

HIPAA – Health Insurance Portability and Accountability Act of 1996.

MARKETING MATERIALS – materials that are produced in any medium, by or on behalf of the PAAS Provider that can reasonably be interpreted as intended to market to potential enrollees.

MEDICAID – the West Virginia Medical Assistance Program operated by the WV Department of Health and Human Resources, Bureau for Medical Services, under Title XIX of the Federal Social Security Act, and related State and Federal rules and regulations.

MEDICALLY NECESSARY SERVICES - covered medical or other health care services, which:

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

MEMBER – a Medicaid eligible or a Title XIX eligible person who is enrolled with a Provider. This term is used interchangeably with the terms enrollee, patient, recipient, and beneficiary.

OBSTETRICAL SERVICES – means prenatal care, delivery, and sixty- (60) days of postpartum care.

PAAS PROVIDER – a PCP, including a group practice or clinic that serves eligible PAAS enrolled members through assignment or by member choice after completion of a Physician Assured Access System Provider Agreement.

PANEL – as it relates to this agreement, a group of members who have selected a Primary Care Provider for health care as part of the PAAS program.

PATIENT - *see* MEMBER.

PCP - primary care provider.

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

PREVENTIVE CARE - the treatment to avert disease, illness, or their consequences.

PRIMARY CARE – all health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, nurse practitioner or pediatrician, to the extent that furnishing of those services is legally authorized in the state in which the practitioner furnishes them.

PRIMARY CARE CASE MANAGEMENT – A system under which a PCP contracts with the State of WV to furnish case management services, which include the location, coordination, and monitoring of primary health care services to Medicaid recipients. Services may include, but are not limited to:

- providing direct health care to patients; including necessary EPSDT screenings and immunizations;
- providing medically necessary specialty referrals, including standing referrals;
- coordinating admissions to hospitals;
- making appropriate referrals to community resources;
- coordinating and monitoring all family centered medical care on behalf of a member;
- coordinating with community mental health professionals; and/or
- educating patients to appropriate use of medical resources such as emergency departments.

PRIMARY CARE CASE MANAGER – a physician, a physician group practice, or an entity that employs or arranges with physicians to furnish care case management services, or, at the State's option, may include a nurse practitioner.

PROHIBITED AFFILIATIONS – a professional relationship with an individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation.

PROVIDER – a health care practitioner who meets the requirements of the WV Medicaid program and is a member of the PAAS network as it relates to this agreement.

QUALITY ASSURANCE - the formal set of activities to assure a standard of quality of services provided. Quality assurance includes assessment and corrective actions taken to remedy and identify deficiencies. Comprehensive quality assurance includes mechanisms to ensure the quality of health care, administrative, and support services.

QUALITY IMPROVEMENT PROJECT (QIP) - a project designed to improve quality, which includes collection of baseline measures with development and implementation of appropriate interventions, followed by re-measurement.

QUALITY OF CARE - the degree or grade of excellence with respect to medical services received by enrollees, administered by providers or programs, in terms of technical competence, need, appropriateness, acceptability, humanity, structure, etc.

RECIPIENT - *see* MEMBER.

REFERRAL – a written request from a PCP to a specialist for a member needing to access care for a specified frequency or number of visits.

SANCTIONS – A penalty that acts to ensure compliance or conformity.

TANF – Temporary Aid to Needy Families.

URGENT MEDICAL CONDITION – medical care for an unexpected, but not life-threatening, illness or injury that requires attention on the same day that it appears or within 24 hours.

UTILIZATION – rate patterns of service usage or types of service occurring within a specific time. Utilization is generally expressed in rates per unit of population-at-risk for a given period.

ARTICLE 2. PROVIDER QUALIFICATIONS and RESPONSIBILITIES

2.1 Licenses and Permits

In order to be a PAAS Provider, whether a group or individual, a valid and current contract must first exist between the provider and the WV Medicaid Program. In addition, provider numbers for each office requesting to be enrolled in the PAAS Program be assigned provider numbers from the Medicaid enrollment unit, or unique identifiers, prior to enrollment in the PAAS Program.

The Provider shall comply with federal regulations regarding prohibited affiliations. Violation of this paragraph at the agreement's execution, or during any part of the term of the agreement, shall immediately render the agreement void. Additionally, the Provider shall comply with all Federal and State laws and regulations, including title VI of the Civil Rights Act of 1964; title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Americans with Disabilities Act; and other laws regarding privacy and confidentiality.

2.2 Provider Responsibilities

1. Each PCP **must** remain an active WV Medicaid provider while serving as a PAAS Provider.

2. The PCP will provide patient management services, and will provide directly or through referral, comprehensive primary health care services to all eligible Medicaid members who choose or are assigned to the PCP's practice.

3. The PCP will provide for reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment for emergency medical conditions.

4. The PCP will restrict enrollment to members who reside sufficiently near one of the PCP's delivery sites to reach that site within 30 miles or 30 minutes drive time, if applicable, using available and affordable modes of transportation.

5. The PCP will provide for arrangements with, or referrals to, sufficient numbers of physicians and other practitioners to ensure that services under the agreement can be furnished to enrollees promptly and without compromise to quality of care.

6. The PCP will not, on the basis of health status or need for health care services, discriminate against individuals eligible to enroll.

7. The PCP will not refuse a re-enrollment or disenroll or otherwise discriminate against an enrollee solely on the basis of age, sex, race, color, physical or mental handicap, national origin, or type of illness or condition, except when that illness or condition may be better treated by another provider. The PCP will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin.

8. The PCP will not utilize discriminating practices in relation to payer source.

9. The PCP will notify the PAAS Unit of the BMS, and the enrollee in a direct and timely manner of the provider's desire to remove an enrollee from the provider's caseload and will keep the enrollee as a client until another PCP is chosen or assigned.

10. The PCP will assure that any child less than 21 years of age enrolled with the PCP is screened, or has access to screening, according to the requirements of the HealthCheck (EPSDT) periodicity schedule.

11. The PCP will participate in Quality Improvement and will copy and send records needed for quality improvement projects as requested by BMS, or it's designated entities.

12. The PCP agrees to have no affiliation with a person debarred, suspended, or otherwise excluded from Federal procurement activities.

13. The PCP agrees to report suspected fraud and cooperate with investigations or audits, without restrictions, that may be conducted by the State and/or Federal Government.

14. The PCP agrees to abide by all State established marketing guidelines, policies, and procedures.

15. The PCP will comply with any applicable Federal and State laws that pertain to enrollee rights, and ensure that its staff and affiliated providers take those rights into account when furnishing services to enrollees. See Article 4.0, Member Rights and Responsibilities.

16. The Provider shall submit claims for all services provided to PAAS members in the same manner and on the same forms (e.g. HCFA 1500, UB92) used to submit claims for all other WV Medicaid members.

17. The Provider shall render medical services for all members who are enrolled with or who are assigned to the Provider. The Provider may not exclude members who have enrolled with or been assigned to the Provider for treatment because they are new or have not previously been seen by the Provider.

18. The Provider will bill third party payers for services rendered. Please see the Medicaid Provider Manuals for more detailed information and instructions.

2.3 Access to Care

The Provider shall:

1. Provide for reasonable and adequate hours of operation including twenty-four (24) hours per day, seven (7) days per week availability for information, referral, and treatment for emergency medical conditions.

2. The following methods may be utilized by PAAS PCPs to give PAAS enrollees instructions on obtaining care during hours when the office is closed:

    - An answering service, which can contact the PAAS PCP or the medical practitioner's designated medical back up. Telephone systems may not direct enrollees to an emergency department for routine care after hours.
    - A recording directing the patient to call another number to reach the PAAS PCP or the medical practitioner's designated back up. The recording may also include information concerning the actions to take in a medical emergency.
    - Automatic call forwarding to another number or pager that is answered by the PAAS PCP or the medical practitioner's designated medical back up.

3. The Provider must make a medical evaluation of the member or refer to an appropriate provider in order for an evaluation to be made within twenty-four (24) hours with appropriate treatment and follow up as deemed medically necessary for those members with an urgent medical condition. Treatment for non-urgent medical problems must be available within three (3) weeks. This standard does not apply to appointments for routine physical exams, nor for regularly scheduled visits to

monitor a chronic medical condition, if that condition calls for visits to occur less frequently than once every three weeks.

4. The PCP may authorize referral of the PAAS patient to another primary care provider or urgent care facility if an acute care visit is requested at a time when no office appointments are available.

5. If the provider will not offer covered services based upon moral or religious objections, he/she shall refer the recipient to another provider.

2.4 Emergency Medical Conditions and Care

Emergency medical conditions are a covered service and do not require a referral from a PCP. However, the emergency room is intended for evaluation and treatment of medically necessary emergency conditions. It is not appropriate for providers to refer patients to the emergency room for non-emergency conditions or as their on-call referral/and information sources. Medical care for non-emergency medical conditions shall be provided in the office setting. In order to encourage appropriate continuity of care, Providers shall advise members of the proper use of the emergency room. The BMS will monitor emergency room service utilization for appropriateness by both member and Provider.

The Provider shall not require members to seek prior authorization for services in a medical emergency.

2.5 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) or HealthCheck

The Provider will render EPSDT services or make arrangements for EPSDT services to be provided to his/her eligible members in accordance with the HealthCheck periodicity schedule.

PCP authorization and referrals can be made to other providers or school-based and local health departments for EPSDT screenings.

2.6 Administrative Responsibility

The Provider shall:

1. Report to the PAAS unit any practice changes, including professional staffing; location; physical plant such that might change physical accessibility; patient access phone; provider class (e.g., individual to group); caseload; and new-patient policy.

2. Submit such practice change information to the PAAS Program, in writing, at the following mailing address or fax number:

West Virginia Bureau for Medical Services
Office of Medicaid Managed Care
PAAS Program
350 Capitol Street, Room 251
Charleston, WV 25301-3708
Fax: (304) 558-4398

2.7 Record Keeping and Reporting

The Provider shall:

1. Establish and maintain a unified medical record for each member that is consistent with current professional standards. The records shall document all care rendered by or through the Provider.

2. Document in the member's medical record each referral to other health care providers. The PCP shall also keep a copy of each medical report(s) by the health care provider for each member referral. If a medical report is not returned, the Provider will contact the health care provider to whom the referral was made to obtain such report(s). Services that do not require a referral from the PCP include obstetrical/gynecological care, family planning services, most vision, hearing and dental services, behavioral health services, pharmacy services, and emergency room care.

3. Coordinate and record referrals for the EPSDT (HealthCheck) program and obtain documentation of the EPSDT evaluation outcome.

4. Maintain medical records and documentation according to Medicaid guidelines, maintaining a separate, unified patient medical record for each enrollee and assuring that all members have a current medical history.

5. The PCP will provide the BMS and the DHHR, or duly designated representatives with access, including on-site inspections and review, to all records relating to the provision of services under this agreement and retain such records for at least five (5) years from the date of creation or until any on-going audits have been settled, if longer.

6. Comply with requests from the Office of Surveillance and Utilization Review (OSUR). The BMS shall utilize a special unit to assist in detecting overutilization and inappropriate billing practices within the PAAS program. The OSUR is responsible for monitoring utilization of Medicaid services. Monitoring efforts include, but are not limited to, on-going utilization analysis, utilization review, and post-payment review techniques.

2.8 Confidentiality

1. The Provider agrees to guard the confidentiality of member information and protect from unauthorized disclosures.

2. Access to member identifying information shall be limited by the Provider to persons or agencies which require the information in order to perform their duties in accordance with this agreement, including the BMS, the U.S. Department of Health and Human Services, the Medicaid Fraud Unit, and other individuals or entities as may be required by the BMS.

3. The Provider agrees to comply with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and comply with any other applicable Federal and State laws regarding privacy and confidentiality.

4. The Provider must obtain the individual's consent prior to using or disclosing protected health information not in compliance with HIPAA.

5. The Provider may, without consent, use or disclose protected health information to carry out treatment, payment, or health care operations, if the covered health care provider has an indirect treatment relationship with the individual.

6. The Provider may, without prior consent, use or disclose protected health information, in order to carry out treatment, payment, or health care operations, that is created or received under the following conditions:

    a. In emergency treatment situations, if the covered health care provider attempts to obtain such consent as soon as reasonably practicable after the delivery of such treatment

b. If the covered health care provider is required by law to treat the individual, and the covered health care provider attempts to obtain such consent but is unable to obtain such consent, or

c. If a covered health care provider attempts to obtain such consent from the individual but is unable to obtain such consent due to substantial barriers to communicating with the individual, and the covered health care provider determines, in the exercise of professional judgment, that the individual's consent to receive treatment is clearly inferred from the circumstances.

7. The Provider agrees that members have the right to request that the PCP restrict how protected health information is used or disclosed to carry out treatment, payment, or health care operations.

8. The Provider must not disclose any individual health care identifiers to members' family, friends, or other entities, without the member's express written permission, except when permissible by law.

2.9 Marketing Guidelines

As it relates to this agreement, marketing is defined as any communication from a PAAS Provider to a Medicaid recipient who is not enrolled in that entity, that can reasonably be interpreted as intended to influence the recipient to enroll in that particular PCCM's practice, or either to not enroll in, or to disenroll from, another managed care entity, such as an MCO or other PCCM practice.

1. The PAAS program has established guidelines for appropriate provider marketing activities to ensure fair and consistent marketing activities are directed toward PAAS members.

2. The PCP may engage in marketing activities related to PAAS program members, provided that such activities do not conflict with state, local, and/or federal regulations.

3. The PCP must receive approval from the Office of Medicaid Managed Care BEFORE distributing any marketing materials.

4. Approved marketing materials MUST be distributed to the entire service area, and may not be specifically directed at individual enrollees or potential enrollees.

5. Marketing materials MUST NOT be designed to influence enrollment in conjunction with the sale or offering of any private insurance.

6. Marketing activities and approaches MUST NOT include the offering of 'gifts' to entice members or potential enrollees to select a specific provider as his/her PCP. Magnets, phone labels, and other nominal items that reinforce a provider's care coordination efforts MAY be approved by the Office of Medicaid Managed Care, but MUST be pre-approved.

7. Marketing activities MUST NOT, directly or indirectly, involve door-to-door, telephone, or other cold-call techniques.

8. The PCP must ensure that marketing activities and materials contain accurate information.

9. Marketing activities and materials MUST NOT mislead, confuse, or defraud the recipients of the PAAS program.

10. Any marketing activities or distributed materials that attempt to intimidate, coerce, or threaten a recipient's benefits will result in immediate sanctions.

11. Forbidden marketing activities include, but are not limited to, the following:

- Asserting or implying that a recipient will lose Medicaid Program benefits if he/she does not enroll in a certain Medicaid Program or select a particular provider as his/her PCP, or creating other threatening scenarios that do not accurately depict the consequences of choosing another plan or provider.
- Program, including any assertion that the entity is endorsed by CMS, Federal or State Governments, or about the disadvantages of other available options.
- Asserting or implying that the PAAS program offers unique covered services, or advertising covered services outside the PAAS-approved benefits.
- Engaging in marketing activities or disseminating marketing materials to potential enrollees prior to obtaining approval from the PAAS program.
- Conducting any form of individual or group solicitation activities other than those expressly permitted by the PAAS program.

12. If a population speaks another language in the providers' service area that comprises greater than 5% of the total county population, approved marketing materials must be translated into that language.

13. Any type of marketing activity that has not been **clearly specified** as permissible under PAAS program marketing guidelines should be assumed to be prohibited.

ARTICLE 3. MEMBER ENROLLMENT

3.0 Selection of a Primary Care Provider

1. The WV DHHR and BMS will provide accurate oral and written information needed to make informed decisions regarding enrollment, and shall offer all members the opportunity to choose an appropriate PCP from a directory of available PAAS PCPs. Families with more than one member will be allowed to choose a different PCP for each family member.

2. If the recipient loses Medicaid eligibility for a period of 2 months or less and becomes eligible again, the recipient will be re-enrolled with the last provider chosen or assigned.

3. Enrollment with a PCP will take effect at the beginning of the following month unless the enrollment is after the preset cut-off date for enrollment, usually around the 20th of each month. Any enrollment after that date will not be effective until the month following the next month. BMS will supply the Provider with his/her updated enrollee roster on or around the first day of each month.

4. The Provider may specify a limit to the number of Medicaid members he/she is willing to accept into his/her practice, and agrees to accept enrollees in the order in which they apply without restriction, not to exceed 1,500 per PCP Full-time Equivalent (FTE) or the limits established by the provider.

5. The Provider may request a change in his/her capacity by submitting a written request to the PAAS unit. Upon review and approval, the BMS will typically implement an effective date of the change on the first day of a month or at the discretion of the PAAS Director. In the event the Provider requests a lower capacity, BMS may lower the capacity, but will not disenroll members to achieve that number. The capacity will be reset and will be allowed to adjust as members change PCPs or lose eligibility.

3.1 Member Disenrollment/Changing PCPs

1. The BMS or enrollment broker may change a member's enrollment from the Provider to another PCP under the following circumstances:

- Upon the member's verbal or written request without cause;
- When the Provider terminates his/her participation in the PAAS program;
- The member has moved out of the PAAS service area and address change has been verified by DHHR;
- The enrollee needs services not provided by the present PCP and lack of services would subject the enrollee to unnecessary risk;
- Quality care concerns or lack of access to providers experienced in dealing with the enrollee's health care needs;
- The member has been enrolled in error, as determined by the PAAS program. This includes, but is not limited to, dual eligibility, state custody, or institutionalization; or
- Upon written request of the Provider. See Section 3.2.

* Enrollment with a new PCP will take effect at the beginning of the following month unless the enrollment is after the preset cut-off date for enrollment, usually around the 20th of each month. Any enrollment after that date will not be effective until the first of the second month.

2. If the state agency should change its member disenrollment process, such that enrollees cannot disenroll with their PCP at any time, an adverse decision would be remedied through the grievance process. The grievance process will be completed in time to permit the disenrollment to be effective no later than the first day of the second month following the month in which the enrollee files the request. If the State agency fails to make a determination within the timeframes, the disenrollment will be considered approved.

3. For any change as described, the Provider shall render or approve medically necessary health care for any member who has selected, or been assigned to, the Provider until the member is officially re-assigned. The effective date of change shall be in accordance with PAAS policy.

4. The following process will be utilized to enroll or Re-enroll members:

   - All consumers who are determined eligible for Medicaid and fall within TANF and TANF related categories receive an enrollment packet. The enrollment packet includes a pre-printed enrollment form asking the consumer to choose a PCP or a managed care entity, return the form in the postage-paid envelope, or call 1-800-449-8466.
   - The consumer is required to choose within 45-60 days before being automatically assigned.
   - If a consumer loses eligibility for less than two months, the consumer will be re-enrolled with the same PCP or managed care entity. If the consumer loses eligibility for greater than two months, the enrollment process begins again.

3.2 Disenrollment At Request of the PCP

1. The Provider may request member disenrollment from their panel only when such Provider can expressly substantiate good cause for the member disenrollment. Approvals for Provider requested member disenrollment will be based on the substantiation of 'good cause' only, and may include, but are not limited to, the following justifications:

   - Specialists who serve as PCPs and change their focus of practice;
   - PCPs who must reduce patient maximums (usually accomplished through attrition);
   - PCPs that are not accepting new patients and have been assigned a member without their consent;
   - Enrollees assigned to a PCP's practice in error;
   - Assignments made that do not agree with the age range limitations of the practice;
   - Members who are Medicare beneficiaries;
   - Patients who are noncompliant, including those who violate their contracts or treatment plans;

- Enrollees who repeatedly do not keep appointments;
- Enrollees who have been discharged from the practice because of abusive, uncooperative, or disruptive behavior unrelated to diminished mental capacity resulting from a special need; or
- Continued enrollment impairs the provider's ability to furnish services.

2. Requests for member disenrollment must be submitted to the PAAS unit, in writing at the following address:

WV Bureau for Medical Services
PAAS Program
350 Capitol Street, Room 251
Charleston, WV 25301-3708

3. Alternatively, the PCP may submit member disenrollment requests via fax, at (304) 558-4398.

4. No PCP member disenrollment requests will be approved under the following circumstances:

- Adverse change in the enrollee's health status;
- Enrollee's utilization of medical services;
- Diminished mental capacity;
- Uncooperative or disruptive behavior resulting from a special need; or
- PCP's belief that member geographics hinder care access.

5. Upon request, the provider shall submit the member's medical record to BMS for medical review to verify that such provider requested member disenrollment does not violate any local, state, or federal discrimination regulations.

6. The Provider shall provide or approve services for the enrollee until the transfer to a new PCP is completed.

7. The member will not be enrolled with the same PCP again, unless the PCP agrees to the enrollment in writing. Under these circumstances, member re-enrollments will not be approved within 3 months of disenrollment.

3.3 Disenrollment By the Bureau for Medical Services

If the BMS terminates its Medicaid contract or PAAS agreement, PAAS has the responsibility of disenrolling all PAAS members from the PCP's panel and re-enrolling the members to a new PCP after appropriate notification is provided to the member.

ARTICLE 4.0 MEMBER RIGHTS and RESPONSIBILITIES

As a member of the PAAS Program, enrollees have the right to:

- Be treated fairly, with dignity and respect;
- Choose his/her own doctor;
- Change his/her own doctor;
- Access to health care services 24-hours a day, seven days a week;
- Participate in his/her own health care decisions and refuse care;
- Have his/her doctor explain treatments, options, and any follow-up that is needed;
- Ask questions and have them answered;
- Know that his/her medical records and any discussions with a provider are private;

- Request and receive a copy of his/her medical records, and request they be amended or corrected;
- Make a complaint to PAAS or to the Department of Health and Human Resources without adversely affecting his/her services;
- Have complaints answered within 30-days;
- To receive oral interpretation for any language, free of charge, and in alternative formats that take into consideration any special need; and to
- To be free from any form of restraint or seclusion.

As a member of the PAAS Program, enrollees have the responsibility to:

- Learn his/her rights as a member of PAAS;
- Keep scheduled appointments and cancel all appointments that cannot be kept;
- Keep up-to-date on all immunizations
- Tell provider about his/her health needs;
- Treat providers with respect;
- Contact his/her PCP first for care that is not an emergency;
- Get a referral from his/her PCP before getting care from a specialist; and
- Actively participate in his/her plan of treatment.

ARTICLE 5. RESPONSIBILITIES of BMS and the PAAS PROGRAM

The PAAS Program will:

1. Pay a monthly Care Management Fee every month for each enrollee on the PCP's panel in addition to fee for service or cost-based payment methods specified by regulations;
2. Distribute to the PCP a monthly roster of beneficiaries enrolled with each PCP/Practice;
3. Analyze data to determine practice patterns and service utilization and provide the PCP or clinic with appropriate reports of utilization and costs for PAAS services at such intervals as deemed appropriate;
4. Provide technical assistance related to HealthCheck (EPSDT) services;
5. Provide all enrollment notices, informational materials, and instructional materials relating to enrollees and potential enrollees in a manner and format that may be easily understood;
6. Provide enrollees with the following information upon enrollment and yearly thereafter:

    - basic features of managed care;
    - names, location, 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;
    - any restrictions on the enrollee's freedom of choice among network providers;
    - information on grievance and fair hearing procedures;
    - the scope of benefits, amount, and duration available;
    - procedures for obtaining benefits, including authorization requirements;
    - the extent to which, and how, enrollees may obtain benefits, including family planning services from out-of-network providers;
    - the extent to which, and how, after-hours and emergency coverage are provided, authorization requirements, right to use any facility for emergency services, and poststabilization services;
    - policy on referrals for specialty care;
    - cost sharing, if applicable;
    - how and where to access any benefits that are available under the State plan but are not covered under the contract;

- access to transportation services; and

7. Assist enrollees and potential enrollees in understanding the PAAS program, benefits, and requirements; notifying the enrollee with written notice of any significant change in the information provided in number 6.
8. Establish a methodology for identifying the prevalent non-English languages spoken by enrollees and potential enrollees throughout the State;
9. Notify and make available to members, written information in each prevalent non-English language;
10. Notify enrollees and potential enrollees that oral interpretation services are available through the enrollment broker and free of charge to each potential enrollee and enrollee, and provide instructions on accessing services. (This applies to all non-English languages, not just those that the State identifies as prevalent);
11. Provide alternative formats in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency; and
12. Inform all enrollees and potential enrollees that information is available through the enrollment broker in alternative formats and how to access those formats.
13. Provide written notice of termination of a contracted provider within 15 days of receipt of termination notice to each enrollee who received primary care services from, or was seen on a regular basis by, the terminated provider.
14. Notify members of any significant changes in the program at least 30 days before the intended effective date of the change.

ARTICLE 6.0 SANCTIONS

6.1 Sanctioning Process

1. In accordance with Subpart I, § 438.700 of the Balanced Budget Act of 1997, each state that contracts with a PCCM may establish sanctions. The State may base its determinations on findings from onsite surveys, enrollee or other complaints, financial status, or any other source.

2. Failure to comply with local, state, and federal regulations and provider agreement obligations may also constitute sanctioning.

3. BMS has established intermediate sanctions that may be imposed if it makes the following determinations:

   a. The PCP fails substantially to provide medically necessary services that he/she is required to provide, under law or under its agreement with the PAAS program, to an enrollee covered under the agreement.
   b. The PCP imposes enrollee premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.
   c. The PCP acts to discriminate among enrollees on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to reenroll a recipient, except as permitted under the PAAS program, or any practice that would reasonably be expected to discourage enrollment by recipients whose medical condition or history indicates probable need for substantial future medical services.
   d. The PCP misrepresents or falsifies information that it furnishes to CMS or to BMS.
   e. The PCP misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider.
   f. The BMS determines that the PCP has distributed 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.

g. The PCP has violated any other local, state, or federal regulation that the PAAS program or BMS determines to be contradictory to any element of this agreement.

4. The PAAS Program has established the following procedure for imposing provider sanctions:

a. Upon documentation of one instance of failure to follow the provisions of the PAAS agreement, the PAAS program will notify the provider via letter detailing the issue identified and request corrective action within 30 days.
b. The PAAS Program will monitor compliance after the 30-day period.
c. If corrective action has not remedied the situation, the provider will be notified of the corrective action that needs to be implemented immediately via certified letter.
d. If the provider has not corrected the situation within 5 working days, the provider will be notified via certified letter that the PCCM management fee will be discontinued and assignment of members will be discontinued as a result of the failure to comply with the provider agreement.
e. The PAAS Program will monitor the implementation of corrective action after one month's enrollment and member assignments and management fees have been discontinued.
f. If corrective action has not been taken at this point, the provider will be notified via certified letter that his agreement with the PAAS Program will be terminated.
g. The PCP may request administrative review pursuant to Common Chapter 700 of the Medicaid Provider Manual by contacting:

Commissioner, Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, WV 25301-3708

h. Enrollees will be notified of their right to choose another PCP within the PAAS provider network.

5. BMS retains the authority to impose additional sanctions under State statutes or State regulations that address areas of noncompliance.

6.2 Notice of Sanction and Pre-Termination Hearing

The State may choose to terminate this agreement if it is determined that the provider has failed to carry out substantive terms of this agreement. Before terminating the provider agreement, the PCP shall receive timely written notice that explains the following:

- The basis and nature of the sanction;
- Other due process protections that the State elects to provide;
- Provide the PCP with the option of a pre-termination hearing (if applicable);
- Provide the PCP with written notice of the PAAS program's intent to terminate, the reason for termination, and the time and place of the hearing;
- Provide the PCP with written notice of the hearing decision, either affirming or reversing the proposed termination of the agreement and, for an affirming decision, the effective date of termination;
- After PCP notification of the PAAS program's intent to terminate, the State may provide the PCP's PAAS enrollees written notice of such intent; and
- Enrollees are allowed to disenroll immediately without cause.

ARTICLE 7.0 AGREEMENT, EFFECTIVE DATE, DURATION and TERM

7.0 General

The Commissioner, Bureau for Medical Services or his/her designee shall administer this agreement.
The initial term of this agreement shall commence on the date of the signature of the person(s) authorized to enter into this agreement and shall automatically renew for successive one (1) year periods, providing that all terms of the agreement remain in effect until amended or terminated. Notice by the PCP of intent to terminate the agreement will not relieve the PCP of the obligation to provide services pursuant to the terms of this agreement until all enrollees are reassigned.

7.1 Termination from Participation

1. Participating PCPs must notify the BMS sixty- (60) days in advance of termination of PAAS status to allow for enrollee reassignment.

2. Clinics must notify PAAS within thirty- (30) days of the departure or withdrawal from PAAS of a PCP who has co-signed a PAAS agreement. If reassignment of enrollees is necessary, as a result of such PCP departure, the clinic will be allowed up to ninety- (90) days from the date of the employee's departure to secure additional staff. After such time, the PAAS Program may proceed with member assignment according to the PAAS Program's regulations regarding provider panel limits.

3. Any physician or clinic terminated from Medicaid or PAAS participation for any reason shall have available any rights of review and appeal otherwise provided for by law and regulations. In addition, the provider may appeal the proposed termination directly to the Commissioner for BMS within thirty- (30) days of the receipt of the notice of termination. The hearing decision of the Commissioner with regard to termination from PAAS shall be the final decision of the BMS subject to due process requirements.

4. This agreement terminates automatically upon the death of the individual signatory physician; sale of the practice, closure or bankruptcy; or termination of participation as a provider in the Medicaid Program.

5. BMS may terminate the agreement immediately upon written notice to the provider when such is considered necessary by the Program to assure the continuance of necessary and appropriate service to PAAS beneficiaries.

6. Upon termination, voluntary or involuntary, claims for services rendered must be submitted within one (1) year from the date of service.

ARTICLE 8.0 HOLD HARMLESS

The Provider shall hold harmless and indemnify the State, and any of its officers, agents, and employees from:

1. Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of State or Federal Medicaid regulations or statutes, by the Provider, his/her partners, coworkers, employees, or subcontractors in the performance of the contract.
2. Any claims for damages or losses resulting to any person or firm injured or damaged by the Provider, his/her partners, coworkers, employees, or subcontractors by the publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under this contract in a manner not authorized by this agreement or by Federal or State regulations or statutes.

3. Any failure of the Provider, his/her partners, coworkers, employees, or subcontractors to observe the Federal or State laws, including, but not limited to, labor laws and minimum wage laws.
4. Any claims for damages, losses, attorney fees, or costs associated with legal expenses, including, but not limited to, those incurred by or on behalf of the State in connection with the defense of claims for such injuries, losses, claims, or damages specified above.
5. The PCP/Clinic agrees to accept and be responsible for their own acts or omissions, and those of their employees, in the professional practice of medicine. Nothing in this agreement shall be construed to place any such responsibility for professional acts or omissions on the DHHS and/or the BMS.
6. The DHHR and/or BMS similarly agree to be solely responsible for its own acts and omissions, as well as those of its employees. Nothing in this agreement shall be interpreted and/or construed to place any such responsibility onto the within named PCP/Clinic.

ARTICLE 9.0 ADDENDUMS

1. This agreement is not considered effective until completion of all required information on the addendums to this agreement, which are necessary to keep the PAAS provider database current.

2. Any notices sent to the BMS in accordance with this agreement shall be sent to:

WV Bureau for Medical Services
PAAS Program
350 Capitol Street, Room 251
Charleston, WV 25301-3708

3. Any notice to the Provider will be mailed to the remittance voucher address on the Medicaid Provider Application.

4. Private Practices, Group Practices or Clinics enrolled in the PAAS Program must notify BMS of any new provider to their staff. The Practices or Clinic is responsible to ensure that all physicians and/or non-physician professionals treating PAAS beneficiaries are properly enrolled in the PAAS Program.

PAAS Program Provider Agreement Signature Pages begin on page 19 of this agreement.

AGREEMENT FOR PARTICIPATION
STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Bureau for Medical Services
PO Box 625
Charleston, WV 25322
1-800-982-7227 (within West Virginia)

PRACTICE INFORMATION			**Please Print or Type**
Name of Practice			Telephone Number
Address	City	State	Zip Code
Practice Fax Number	FEIN Number	Practice Medicaid ID Number	

Provider Type:

- ❑ **Individual Practice**
- ❑ **Group Practice**
- ❑ **Federally Qualified Health Clinic** (**FQHC)**
- ❑ **Clinic Provider**
- ❑ **Rural Health Clinic (RHC)**

CONTACT FOR PAAS COMMUNICATIONS			
Name		Title	
Address (if different from Practice Address)	City	State	Zip Code
Telephone Number	Fax Number	E-Mail Address	

SINGLE PROVIDER PRACTICE – Please complete and sign this section if the practice has one provider providing Primary Care who is accepting PAAS enrollees.

- ❑ **Not Applicable**

Typed or Printed Name and Title of Participating PCP	Date
Signature of Participating PCP	Specialties:

West Virginia PAAS Program Provider Agreement

GROUP, CLINIC, RHC, OR FQHC PRACTICE – Please complete and sign this section if the practice has more than one provider providing Primary Care who is accepting PAAS members. This section is to be completed with the signature of the Chief Executive Officer or Medical Director. ❑ **Not Applicable**

Typed or Printed Name of Participating Group/Clinic	Date
Typed or Printed Name of Authorized Official	Title of Authorized Official
Signature of Authorized Official	

Practice Status for New Patients

CHOOSE ONE PRACTICE STATUS LISTED BELOW:

□	OPEN PRACTICE:	New Patients Accepted including Auto-Assignment
□	LIMITED PRACTICE:	Accepting New Patients if Selected by Enrollee; Not Accepting Auto-Assignment
□	CLOSED PRACTICE:	Not Accepting New PAAS Enrollees (Written or Verbal Notification Required)

Commissioner, Bureau for Medical Services Signature	Date

PAAS Practice Sites **Site Provider Number**

Site Name (PAAS Practice Site)	County	Number of PAAS Enrollees Accepted at this Site	
Street Address	City	State	Zip Code
Telephone Number	Fax Number		
HealthCheck (EPSDT) Services Information Practice Site HealthCheck Provider Number or HealthCheck Referral Provider (Required if serving children)			
Is the practice site handicap/wheelchair accessible?			

Office Hours and General Information at this location

Monday	Thursday	Sunday
Tuesday	Friday	• Provider Language Spoken other than English: _____ • Gender: M F
Wednesday	Saturday	

Practice Staffing Information

Practitioners at this location Full Name	Title	Number of hours at this site per week	Specialty	Genders Accepted Male/Female/Both	Age Limits Minimum & Maximum