Comments and Answers for Chapter 527 Mountain Healt

	Date Received	Comment	Status Result
1	2/19/2018	527.1 - Consideration should be given that residential services will be covered in managed care benefit due to SUD Waiver.	No Change
2	2/19/2018	527.2 - Foster Care is expected to transition within a year.	No Change
3	2/19/2018	527.2 - Except for newborns , qualification should be made for members in period of retroactive eligibility.	Change
4	2/19/2018	527.3 - The requirement that MCOs must obtain approval from the Office of the Insurance Commission (Certificate of Authority).	Change
5	2/19/2018	527.3 - Qualification for new entry needed concerning accreditation by NCQA.	No Change
6	2/19/2018	527.4.1 - The source of authority for defining minimum state plan covered services should be the contract not BMS manuals.	No Change

7	2/19/2018	527.4.1 - Could the contractual language be followed and Attach Appendix A to the end of this policy. *"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."*	No Change
8	2/19/2018	527.4.1 - Not sure how providers verifying member eligibility is a requirement for covered services. This is a provider responsibility. Move to provider section?	Change
9	2/19/2018	527.4.1 - Providers are required to obtain service authorizations not members.	Change
10	2/19/2018	527.5.3 - The citation in our contract with BMS states compliance with the regulations around Member Appeals/Grievances. It is listed as a requirement, however, the regulation cited is for members not providers. Simply listing here without the regulation citations infers providers are eligible for grievance procedures.	Change

11	2/19/2018	527.6.2 - Continuity of Care should be clarified that it is for a limited time of 90 days or agreed upon time; not indefinitely.	Change
12	2/19/2018	527.6.4 - Provider requirement not a member requirement to obtain necessary authorizations and/or referrals.	Duplicate
13	2/19/2018	527.7.1 - What does the last the sentence in the first paragraph mean? Can it be deleted?	Change

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Action for Change Status	Reasoning for No Change Status and FAQs
	SUD services are in Chapter 504, Substance Use Disorder Services
	The list of covered populations manual is correct at this time.
Changed language to: "Members in a period of retroactive eligibility, except for newborns"	
Added the language, "Obtain certificate of authority from the West Virginia Offices of the Insurance Commissioner" to 527.3.	
	NCQA accrediation is referenced in 527.3.
	The BMS Provider Manual will remain as defining the services.

	The BMS Provider Manual will remain as defining the services.
Removed "Providers must verify member eligibility" from 527.4.1. Added the following language to 527.5.4: "Providers are responsible for verifying members' eligibility either through the fiscal agent's website or the automated voice response system."	
Removed verbiage concerning members obtaining service authorizations in 527.4.1.	
Changed wording of last bullet point to "Include grievance procedures for the members to abide by"	

Bullet point now reads: "Continuity of Care as defined by 42 CFR 438.208 and Service Provider Agreement between BMS and the MCOs." Also added links to the MCO contract and the federal reg.	
Removed verbiage concerning members obtaining service authorizations in 527.6.4.	
Removed the last sentence.	