Request for Quotation

State of West Virginia
Department of Health & Human Resources
Office of Purchasing
One Davis Square, Suite 100
Charleston, WV 25301

RFQ NUMBER	PAGE
MED12009	1

ADDRESS CORRESPONDENCE TO ATTENTION OF
DONNA D. SMITH
304-957-0218

VENDOR	

SHIP TO	
	BUREAU FOR MEDICAL SERVICES 350 CAPITOL STREET, ROOM 251 CHARLESTON, WV 25301-3706

DATE PRINTED	TERMS OF SALE	SHIP VIA	F.O.B.	FUND

BID OPENING DATE: 03/06/12 BID OPENING TIME: 1:30 PM

LINE	QUANTITY	UOP	CAT.NO.	ITEM NUMBER	UNIT PRICE	AMOUNT

ADDENDUM NO. 1

1. TO ANSWER VENDOR QUESTIONS AS PER THE ATTACHED.
2. TO MODIFY THE RFP PER THE ATTACHED.
3. ADDENDUM ACKNOWLEDGEMENT IS ATTACHED. THIS DOCUMENT SHOULD BE SIGNED AND RETURNED WITH YOUR BID. FAILURE TO SIGN AND RETURN MAY RESULT IN DISQUALIFICATION OF YOUR PROPOSAL.

REQUISITION NO.: MED12009

ADDENDUM ACKNOWLEDGEMENT

I HEREBY ACKNOWLEDGE RECEIPT OF THE FOLLOWING CHECKED ADDENDUM(S) AND HAVE MADE THE NECESSARY REVISIONS TO MY PROPOSAL, PLANS AND/OR SPECIFICATION, ETC.

ADDENDUM NO.'S"

NO. 1 _____
NO. 2 _____
NO. 3 _____
NO. 4 _____
NO. 5 _____

I UNDERSTAND THAT FAILURE TO CONFIRM THE RECEIPT OF THE ADDENDUM(S) MAY BE CAUSE FOR REJECTION OF PROPOSAL.

SEE REVERSE FOR TERMS AND CONDITIONS

SIGNATURE	TELEPHONE	DATE

TITLE	FEIN	ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO RFP, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED "VENDOR"

Request for Quotation

State of West Virginia
Department of Health & Human Resources
Office of Purchasing
One Davis Square, Suite 100
Charleston, WV 25301

RFQ NUMBER	PAGE
MED12009	2

ADDRESS CORRESPONDENCE TO ATTENTION OF
DONNA D. SMITH
304-957-0218

VENDOR	

SHIP TO	
	BUREAU FOR MEDICAL SERVICES 350 CAPITOL STREET, ROOM 251 CHARLESTON, WV 25301-3706

DATE PRINTED	TERMS OF SALE	SHIP VIA	F.O.B.	FUND

BID OPENING DATE: 03/06/12 BID OPENING TIME: 1:30 PM

LINE	QUANTITY	UOP	CAT.NO.	ITEM NUMBER	UNIT PRICE	AMOUNT

VENDOR MUST CLEARLY UNDERSTAND THAT ANY VERBAL REPRESENTATION MADE OR ASSUMED TO BE MADE DURING ANY ORAL DISCUSSION HELD BETWEEN VENDOR'S REPRESENTATIVES AND ANY STATE PERSONNEL IS NOT BINDING. ONLY THE INFORMATION ISSUED IN WRITING AND ADDED TO THE SPECIFICATIONS BY AN OFFICIAL ADDENDUM IS BINDING.

SIGNATURE

COMPANY

DATE

END OF ADDENDUM NO. 1

SEE REVERSE FOR TERMS AND CONDITIONS

SIGNATURE	TELEPHONE	DATE

TITLE	FEIN	ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO RFP, INSERT NAME AND ADDRESS IN SAPCE ABOVE LABELED "VENDOR"

GENERAL TERMS & CONDITIONS
PURCHASE ORDER/CONTRACT

1. ACCEPTANCE: Seller shall be bound by this order and its terms and conditions upon receipt of this order.

2. APPLICABLE LAW: The laws of the State of West Virginia and the BMS Purchasing Manual shall govern all rights and duties under the Contract, including without limitation the validity of this Purchase Order/Contract.

3. NON-FUNDING: All services performed or goods delivered under BMS Purchase Orders/Contracts are to be continued for the terms of the Purchase Order/Contract, contingent upon funds being appropriated by the Legislature or otherwise being made available. In the event funds are not appropriated or otherwise available for these services or goods, the Purchase Order/Contract becomes void and of no effect after June 30.

4. COMPLIANCE: Seller shall comply with all federal, state and local laws, regulations and ordinance including, but not limited to, the prevailing wage rates of the WV Division of Labor.

5. MODIFICATIONS: This writing is the parties' final expression of intent. No modification of this order shall be binding unless agreed to in writing by the Buyer.

6. ASSIGNMENT: Neither this Order or any monies due, or to become due hereunder may be assigned by the Seller without the Buyer's consent.

7. WARRANTY: The Seller expressly warrants that the goods and/or services covered by this order will: {a} conform to the specifications, drawings, samples or other description furnished or specified by the BUYER; {b} be merchantable and fit for the purpose intended; and/or {c} be free from defect in material and workmanship.

8. CANCELLATION: The director of the DHHR Office of Purchasing may cancel any Purchase Order/Contract upon 30 days written notice to the seller.

9. SHIPPING, BILLING & PRICES: Prices are those stated in this order. No price increase will be accepted without written authority from the Buyer. All goods or services shall be shipped on or before the date specified in the Order.

10. LATE PAYMENTS: Payment may only be made after the delivery of goods or services. Interest may be paid on late payments in accordance with the ***West Virginia Code*** .

11. TAXES: The State of West Virginia is exempt from the federal and state taxes and will not pay or reimburse such taxes.

12. RENEWAL: Any reference to automatic renewal is hereby deleted. The Contract may be renewed only upon contract null and void, and terminate such contract without further order.

13. BANKRUPTCY: In the event the vendor/contractor files for bankruptcy protection, the State may deem this contract null and void, and terminate such contract without further order.

14. HIPAA BUSINESS ASSOCIATE ADDENDUM: The West Virginia State Government HIPAA Business Associate Addendum (BAA), approved by the Attorney General, is available online at www.state.wv.us/admin/purchase/vrc/hipaa.htm and is hereby made part of the agreement provided that the Agency meets the definition of a Cover Entity (45 CFR § 160.103) and will be disclosing Protected Health Information (45 CFR § 160.103) to the vendor.

15. CONFIDENTIALITY: The vendor agrees that he or she will not disclose to anyone, directly or indirectly, any such personally identifiable information or other confidential information gained from the agency, unless the individual who is the subject of the information consents to the disclosure in writing or the disclosure in writing or the disclosure is made pursuant to the agency's policies, procedure, and rules.

16. LICENSING: Vendors must be licensed and in good standing in accordance with any and all state and local laws and requirement by any state or local agency of West Virginia, including but not limited to, the West Virginia Secretary of State's Office, the West Virginia Insurance Commission, or any other state agency or political subdivision. Furthermore, the vendor much provide all necessary releases to obtain information to enable the Director or spending unit to verify that the vendor is licensed and in good standing with the above entities.

Ques. #	RFP Section	RFP Page	RFP Requirement	Question	Answer
1.	2.5.8		The Vendor shall provide additional services to comply with externally driven changes to BMS programs and requirements, including any State or Federal laws, rules, and regulations. Additional Services shall be bid as an all-inclusive hourly rate and shall require Bureau approval of a Statement of Work (SOW) and submission of related Cost Estimate.	In the previous contract, how many times was the incumbent required to provide additional services? How many total hours? Can you further clarify what is meant by 'an all-inclusive' hourly rate?	The incumbent was never asked to provide additional services. The Vendor's all-inclusive hourly rate will include all general and administrative staffing (secretarial, clerical, etc.), travel, supplies and other resource costs necessary to perform all services within the scope of this procurement.
2.	3.4.1		Vendors should allow sufficient time for delivery. In accordance with the Medicaid Services Contracts Purchasing Methodology and Manual, the Bureau cannot waive or excuse receipt of a proposal, which is delayed or late for any reason. Any proposal received after the bid opening date and time will be immediately disqualified. Vendors responding to this RFP shall submit: One (1) original technical and cost proposal plus six (6) convenience copies, including one (1) copy on cd to:	Does this mean 1 + 5 copies + CD or 1 + 6 copies + CD?	1 + 6 copies + CD.
3.	3.5		In accordance with Medicaid Services Contracts Purchasing Methodology and Manual, all bidders must submit an affidavit regarding any debt owed to the State of West Virginia. The affidavit must be signed and submitted prior to award. It is preferred that the affidavit be submitted with the proposal. http://www.dhhr.wv.gov/bms/ProcurementNotices/Documents/RFPs/MED_PURCHASING_AFFIDAVIT.pdf	Should this be submitted as a stand-alone document?	It is preferred that the affidavit be submitted with the proposal, however this may be submitted as a stand-alone document upon notification from the DHHR Office of Purchasing of being the apparent successful vendor.

Ques. #	RFP Section	RFP Page	RFP Requirement	Question	Answer
4.	5.9		Invoices and Progress Payments: The Vendor shall submit invoices, in arrears, to the Bureau at the address on the face of the purchase order labeled "Invoice To." Progress payments may be made at the option of the Bureau on the basis of percentage of work completed if so defined in the final contract.	Can you please clarify the method of reimbursement for this award? Is this a fixed price contract or a deliverables based reimbursement method?	Fixed price contract.
5.	5.12.3		License Requirements: Provide certification that Vendor is registered with the Secretary of State's Office to do business in West Virginia; provide evidence that Vendor is in good standing with the State Agency of Employment Programs as to Unemployment Compensation coverage and the Office of the Insurance Commissioner as to Worker's Compensation coverage or exempt from such	What evidence of Unemployment Compensation coverage and Worker's Compensation coverage standing does an out-of-state vendor need to provide?	Vendor will need to contact WORKFORCE West Virginia at www.workforcewv.org or by phone at 304-558-2451 regarding Unemployment Compensation coverage and the Offices Of The Insurance Commissioner www.wv.insurance.gov or by phone at 304-558-6279 regarding Worker's Compensation coverage.
6.				What is the value of the current contract?	The three (3) year value was $1,734,567.00. BMS extended this contract for one (1) year for an additional cost of $601,008.00
7.				What is the value of the proposed contract?	This information will not be provided as price is not the sole determining factor and the award will be based on a combination of cost and technical factors (Best Value).

Ques. #	RFP Section	RFP Page	RFP Requirement	Question	Answer
8.				What is the estimated start date for the proposed contract?	April 1, 2012.
9.				Is the current EQRO contract available through the BMS web site, or will the Bureau make available the current EQRO contract for bidders to review?	No, bidders will need to file a FOIA request with the DHHR Office of Purchasing.
10.	2.2	3		Is the BMS contract with its three MCOs available on line for bidders to access? If yes, please provide the link. If not, will BMS make the contract available for bidders?	BMS' contract with the three MCOs is not available on line; however BMS will make a copy of a contract available for bidders with the issuance of Addendum No. 1. The contract provided is for CareLink; however the contractual obligations are the same for all MCOs. Exhibit B was removed from the contract due to the inclusion of proprietary information.
11.	2.2	3		Does the BMS anticipate a change to the number of managed care organizations during the term of this contract? If so, when and to how many?	West Virginia allows all qualified entities willing to accept Medicaid payment rates to participate in the State's Medicaid managed care program. BMS does not have any planned changes to the number of managed care organizations during the term of this contract.
12.	2.2	3	paragraph 3	RFP mentions the state's PAAS program, will this require an audit as well or are only the 3 MCOs required to be audited?	Only contracted MCOs will be audited.

Ques. #	RFP Section	RFP Page	RFP Requirement	Question	Answer
13.	2.2	4		For purposes of assessing MCO compliance using the non-duplication strategy under 42 CFR 438.360, are the MCO's required to obtain a particular type of national accreditation, and if so, which one? Are any/all of the MCOs certified under Medicare?	In accordance with Section 33-25A-17(c) of the West Virginia Code, MCOs are required to obtain accreditation to operate within the State. However, MCOs are not required to obtain specific accreditation for their Medicaid line of business. MCOs in West Virginia may choose which accrediting body to seek accreditation from, including NCQA and URAC. The Health Plan of the Upper Ohio Valley is accredited by NCQA for its Medicare line of business.
14.	2.2	4	paragraph 3	How many performance measures are the MCOs required to calculate and have audited?	The number of performance measures the MCOs are required to calculate varies annually based on direction from BMS and the EQRO. After consultation with BMS, the EQRO will provide this direction to the MCOs during the onsite orientation meeting with the MCOs and BMS. BMS encourages vendors to include all reportable HEDIS performance measures within the audit.
15.	2.2	4	paragraph 3	Are the performance measures HEDIS, AHRQ, CHIPRA, or state-developed measures?	BMS uses relevant HEDIS measures to assess MCO quality performance.
16.	2.2	4	paragraph 3	Are the measures reported administratively or using medical record review (hybrid) reporting?	The reported measures follow both administrative and hybrid reporting approaches, as appropriate.
17.	2.4	5		Is the State's Medicaid quality strategy available for potential vendor's review?	No, it is not available at this time for review by potential vendors.

Ques. #	RFP Section	RFP Page	RFP Requirement	Question	Answer
18.	2.4	5		While not stated explicitly in the RFP, the phrase "work with MCOs to improve results" appears to imply a role for the EQRO in developing corrective actions or assisting with implementation of improvement actions of the MCOs. Please specify the BMS's expectations for the EQRO's role in corrective or improvement actions of the MCOs related to each of the three EQR activities.	Based on the results of EQR activities, BMS expects the EQRO to identify areas for quality improvement and make recommendations to BMS on an ongoing basis.
19.	2.4.1 2.4.11	5 and 7		How do tasks 2.4.1 and 2.4.11 differ?	2.4.11 is being deleted.
20.	2.4.2	5		How many performance improvement projects (PIPs) are currently required for each plan that undergo validation by the EQRO?	Each MCO is required to maintain at least two (2) PIPs at a time, but may operate more based on BMS approval.
21.	2.4.2	5		How many PIPs will the EQRO be responsible for validating for each contract year?	Each MCO is required to maintain at least two (2) PIPs at a time, but may operate more based on BMS approval. The EQRO will be responsible for validating all PIPs in operation by the MCOs.
22.	2.4.2	5		Does the BMS require MCOs to conduct a collaborative PIP? If so, what is the topic?	BMS periodically requires MCOs to conduct a collaborative PIP. For example, the MCOs were required to participate in an Emergency Department Collaborative, which has since ended.
23.	2.4.2	5		What are the PIP topics currently underway?	Current PIP topics include: childhood immunizations, emergency room utilization, childhood obesity, and asthma.

Ques. #	RFP Section	RFP Page	RFP Requirement	Question	Answer
24.	2.4.2	5		For the PIPs that are currently underway, are HEDIS measures used for the PIP study indicators?	Yes, PIPs currently underway use HEDIS measures as the PIP study indicators.
25.	2.4.2	5		Will the EQRO be required to produce PIP validation reports for all PIPs submitted for validation? Or, would the BMS prefer to have validation results provided in the annual plan-specific reports only?	The EQRO will be required to produce PIP validation reports for all PIPs submitted for validation. These results should also be included in the annual report.
26.	2.4.2	5		Is it BMS expectation that any PIP technical assistance provided to the plans be on-site or can it be done via conference call or Webinar?	PIP technical assistance should be provided through the most appropriate method, which may be via conference call, webinar, or on-site.
27.	2.4.3	5		How many measures are calculated by the MCOs and how many are calculated by the state?	All HEDIS measures are calculated by the MCOs and certified by the EQRO.
28.	2.4.3	5		Will an audit/onsite visit need to be conducted at the state to review its processes for calculating performance measures?	No, there will not be an onsite visit to be conducted at the state because the state does not calculate the performance measures
29.	2.4.3	5		Is there a certain time of the year the state expects the audits to be conducted or is this at the Vendors discretion?	The vendor should propose a timeframe for conducting audits as part of its response to 2.4.1.
30.	2.4.3	5		Historically have the MCOs completed the NCQA HEDIS Roadmap or CMS ISCAT for these audits?	Historically, the MCOs have completed the NCQA HEDIS Roadmap for audits.

Ques. #	RFP Section	RFP Page	RFP Requirement	Question	Answer
31.	2.4.3	5		Do any of the MCOs use certified software for calculating the performance measures?	At this time, BMS does not require the MCOs to use certified software to calculate the HEDIS performance measures.
32.	2.4.3	5		Where in the state(s) are the onsite PMV audits conducted?	It varies by plan.
33.	2.4.4	5		To reduce MCO burden, is the BMS open to conducting less than a full compliance review each year, considering options such as a review of one-third of the managed care standards in each of three successive years?	No, the EQRO is required to conduct an annual on-site review of each MCO's administrative and operational systems to ensure that the MCO has the appropriate structure in place to meet all program requirements.
34.	2.4.5	6		For 2.4.5, what exactly is the Bureau looking for with this task?	The vendor should review Medicare and private standards and provide recommendations to BMS on approaches for avoiding duplication by relying on other review results from Medicare or other private accreditation organizations, in accordance with 42 CFR 438.360.
35.	2.4.5	6		The RFP states that the EQRO vendor should propose a plan to monitor the Medicare and private standards and processes to review and make recommendations to BMS as to where it may be appropriate to use the Medicare or private review to avoid duplication. Does the reference to "private standards" mean standards associated with national accreditation bodies (NCQA, URAC, etc.)? If no, please specify the applicable source(s) of standards for the private review(s).	Yes, the reference to private standards refers to organizations such as NCQA and URAC.

Ques. #	RFP Section	RFP Page	RFP Requirement	Question	Answer
36.	2.4.6	6		This section requires the EQRO vendor to propose a plan to review the MCO activities that are unique to the MHT program (i.e., grievance and appeals processes, and EPSDT outreach and notices), notify the MCOs of the preliminary review findings and request corrective action plans for insufficient compliance, and provide clarification and/or technical assistance to MCOs as necessary to develop and implement corrective action plans. Is it BMS' expectation that the EQRO vendor will conduct a focused review that is separate from the annual compliance review activities described in Section 2.4.4? If separate, will the review be a review of only the MCO's documentation and/or telephonic interviews or will it require an additional and separate compliance on-site review? Will the results of this activity require a separate written report of results by MCO or will the feedback and technical assistance to each MCO be provided either only verbally (e.g., telephone, Webinars, etc.), as part of the annual compliance review reports, and/or as part of the annual plan-specific reports described in Section 2.4.9, or other? If other, please specify.	No, this review will be a component of the annual compliance review (Section 2.4.4). Feedback to the MCOs should be provided through the report described in Section 2.4.8 and the annual plan-specific reports described in Section 2.4.9.

Ques. #	RFP Section	RFP Page	RFP Requirement	Question	Answer
37.	2.4.8, 2.4.9, and 2.4.10	6		These three sections appear to describe the annual technical report of EQR results required at 42 CFR 438.364, which is the State's annual deliverable to CMS. However, the BMS appears to be requesting separate MCO specific reports of results plus a separate comparative report (five reports total). Please confirm or clarify. In addition, does the BMS wish to receive plan-specific reports of each individual EQR activity (validation of PIPs, validation of performance measures, conducting a review of compliance)?	The vendor will be responsible for drafting the following reports: MCO-specific reports containing information on each EQR activity and the report referenced in Section 2.4.8. BMS does not have a specific preference regarding reporting structure. The vendor should propose how the reports would be organized. A separate comparative report is desired. This report may be utilized to inform stakeholders regarding plan performance.
38.	2.4.11	7		For the yearly Operations Plan, is the BMS requesting a detailed work plan with tasks and timelines for each EQR activity the EQRO will conduct for each of the four years of the contract, or for one year only?	2.4.11 is being deleted.
39.	2.4.10	6		Is it permissible to produce a single EQR technical report, which is required in section 2.4.8, that also includes the comparative information about all MCOs as described in section 2.4.10?	Yes, the detailed technical report can also contain the comparative information about all of the MCOs referenced in Section 2.4.10.

Ques. #	RFP Section	RFP Page	RFP Requirement	Question	Answer
40.	2.5.6	8		The RFP states that the EQRO vendor's project manager or a designated representative is to attend all quarterly meetings of the MHT task force. Will all the meetings be held in Charleston? If not, at what other locations will some/all of the meetings be conducted? Can the EQRO vendor's project manager or designated representative participate in some or all of the meetings through teleconferencing/Webinars?	Yes, all of the meetings will be held in Charleston, West Virginia. The EQRO vendor's project manager or designated representative must attend the Task Force Meeting in-person.
41.	3.3	9	Attachment A	The instructions for Attachment A: Vendor Response Sheet indicate that the response must provide the following: "…firm and staff qualifications and experience in completing similar projects; references; copies of any staff certifications or degrees applicable to this project; proposed staffing plan; descriptions of past projects completed…" Is it the Bureau's preference for the responses above to be incorporated with the discussion of each of the items in Section 2.4, i.e., under 2.4.2 Plan to Validate and Review PIPs there would be firm and staff qualifications/experience, references, copies of staff certifications/degrees, staffing plan, etc.? Or, would the Bureau prefer to have the vendor respond to these requirements prior to beginning response for 2.4.1, 2.4.2, etc.?	The vendor should incorporate firm and staff experience within Sections 2.4 as appropriate. Copies of staff certifications or degrees applicable to the project may be provided as an attachment to the technical proposal.

Ques. #	RFP Section	RFP Page	RFP Requirement	Question	Answer
42.	3.3	9	Attachment A	For the staff certifications and degrees, is the vendor required to provide these documents for all staff proposed for the project, or only for key staff who may be leading/directing the tasks? Can these documents be provided as an attachment to the technical proposal, or should they be included in Attachment A?	Copies of staff certifications or degrees applicable to the project may be provided as an attachment to the technical proposal.
43.	3.6 and 4.2	10 and 11		How is the resident vendor preference used to calculate points awarded?	Such preference is an evaluation method only and will be applied only to the cost bid. Generally, a West Virginia vendor may be eligible for two (2) 2.5% preferences in the evaluation process against an out of state vendors cost.
44.	2	3		Is the scope of this RFP limited to the MCOs or is the primary care case management program (PAAS) also included?	The scope of this RFP is limited to the MCO program.
45.	2.2	4		The RFP indicates that BMS may exercise its authority to rely on other review results such as Medicare or private accreditation reviews, as part of the MHT compliance review. Have prior reviews relied upon results from these other reviews? How many of the MCOs are accredited?	No, prior reviews have not relied upon results from Medicare or private accreditation reviews. All three (3) MCOs are accredited by NCQA for at least one (1) of their lines of business.

Ques. #	RFP Section	RFP Page	RFP Requirement	Question	Answer
46.	2.3	4		The RFP requires that vendors provide "in Attachment A: Vendor Response Sheet information regarding their firm and staff qualifications and experience in completing similar projects; references; copies of any staff certifications or degrees applicable to this project; proposed staffing plan; descriptions of past projects completed entailing the location of the project, project manager name and contact information, type of project, and what the project goals and objectives are and how they were met." Attachment A includes provisions for addressing the goals in Section 2.4. Should the above information be included in one or more of the "goals" discussions or should the above information be provided on Attachment A separate from, and in addition to, the "goals" discussions?	The vendor should incorporate firm and all staff experience within Sections 2.4 and 2.5, as appropriate. Copies of staff certifications or degrees applicable to the project may be provided as an attachment to the technical proposal.

Ques. #	RFP Section	RFP Page	RFP Requirement	Question	Answer
47.	2.4	5		The RFP requires that vendors "address within their proposal how they are able to: • Identify any issues or problems regarding access, quality, and utilization. • Verify MCO compliance with program systems and clinical requirements, as outlined in the MCO contract. • Identify "best practices" and work with MCOs to improve results. • Provide BMS with a comprehensive report that can be used as part of the Bureaus' overall quality strategy. • Prepare BMS and the MCOs for fall review activities that will take place during the year. This approach should include an onsite orientation meeting with the MCOs and BMS. Should these items be included in Attachment A? If so, where within Attachment A. If not, where, within the Technical Proposal should they be addressed?	These items should be addressed in the vendor's response to Sections 2.4 within Attachment A as appropriate.

Ques. #	RFP Section	RFP Page	RFP Requirement	Question	Answer
48.	2.4	5		The RFP requires that vendors "address within their proposal how they are able to: • Prepare BMS and the MCOs for fall review activities that will take place during the year. This approach should include an onsite orientation meeting with the MCOs and BMS. Is this "all review activities" or "fall review activities"?	This should state "all" review activities.
49.	2.4.2	5		The RFP requires that the EQRO validate PIPs annually. What is the number of PIPs subject to review annually?	Each MCO is required to maintain at least two (2) PIPs at a time, but may operate more based on BMS approval. The EQRO will be responsible for validating all PIPs in operation by the MCOs.
50.	2.4.3	5		The RFP requires that the EQRO validate performance measures. Please provide the number and type of measures to be validated, e.g., HEDIS measures, non-HEDIS measures or a combination of both. If HEDIS measures are included, do the MCOs contract with an independent NCQA-licensed HEDIS audit organization to audit these measures?	The number of performance measures the MCOs are required to calculate varies annually based on direction from BMS and the EQRO. After consultation with BMS, the EQRO will provide this direction to the MCOs during the onsite orientation meeting with the MCOs and BMS. BMS encourages vendors to include all reportable HEDIS performance measures within the audit.

Ques. #	RFP Section	RFP Page	RFP Requirement	Question	Answer
51.	2.4.3	5		The RFP requires that the EQRO validate performance measures reported (as required by the State) or MCO performance measures calculated by the State. Please provide the number of measures calculated by the State. If measures will be calculated by the State, should the bidder plan to conduct an assessment of the State's information systems, procedures, etc.?	The number of performance measures the MCOs are required to calculate varies annually based on direction from BMS and the EQRO. After consultation with BMS, the EQRO will provide this direction to the MCOs during the onsite orientation meeting with the MCOs and BMS. BMS encourages vendors to include all reportable HEDIS performance measures within the audit. The measures are not calculated by the State.
52.	2.4.6	6		The RFP requests a plan to review MCO activities that are unique to the MHT program. Is it acceptable to review these activities as part of the annual compliance review?	Yes, this is acceptable.
53.	2.4.8 – 2.4.10	6		Please confirm our understanding that the EQRO is required to produce annual plan-specific technical reports, an aggregate technical report and an aggregate comparative report. How does the aggregate comparative report differ from the aggregate technical report?	Yes, the detailed technical report can also contain the comparative information about all of the MCOs, referenced in Section 2.4.10. A separate comparative report is desired. This report may be utilized to inform stakeholders regarding plan performance. The aggregate comparative report will compare MCOs at a very high level (i.e., report card,). The aggregate technical report should include a much higher level of detail.

Ques. #	RFP Section	RFP Page	RFP Requirement	Question	Answer
54.	2.4.11 and 2.5.5	7		Section 2.4.11 describes a yearly operations plan that includes a timeline of events. Section 2.5.5 requires that a draft work plan be submitted within 30 days of contract award. Are these the same plans? If not, please describe the State's expectations for the content of each plan.	2.4.11 is being deleted.
55.	3.3	8-9		The requirements for the proposal include: Title page, Table of contents, Attachment A, Attachment B, Attachment C, and Attachment D. Please confirm that all information in the Technical Proposal should be contained within these parts. That is, any narrative should be included in Attachment A and not placed between the Table of contents and Attachment A.	This is correct.

Change To RFP	Current RFP Language Reads	RFP Language Updated to Read
2.4 **Project and Goals:**	• Prepare BMS and the MCOs for fall review activities that will take place during the year. This approach should include an onsite orientation meeting with the MCOs and BMS.	• Prepare BMS and the MCOs for all review activities that will take place during the year. This approach should include an onsite orientation meeting with the MCOs and BMS.
2.4.11	Vendor should propose a yearly Operations Plan that addresses compliance with all of the following program requirements: Validating and reviewing PIPs, performance measures and annual compliance reviews. The Operations Plan should include a timeline of events.	Deleted.
4.2 **Evaluation Criteria**	**A.** Qualifications and experience 40 Points Possible **B.** Approach and methodology 30 Points Possible	**A.** Qualifications and experience 20 Points Possible **B.** Approach and methodology 50 Points Possible
Attachment A: Vendor Response Sheet	**Section 2.4.11:** Vendor Response	**Section 2.4.11:** Vendor Response: Section deleted.
Attachment D: Special Terms and Conditions	*If a Vendor's proposal includes proprietary language within the technical proposal, an electronic copy omitting any proprietary language for publishing to the DHHR web-site shall be submitted.*	*If a Vendor's proposal includes proprietary language or personally identifiable information (PII) of vendor employees within the technical proposal, an electronic copy omitting any proprietary language or PII for publishing to the DHHR web-site shall be submitted.*

PURCHASE OF SERVICE PROVIDER AGREEMENT

BETWEEN

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES

AND

CARELINK HEALTH PLANS

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
PURCHASE OF SERVICE PROVIDER AGREEMENT

Table of Contents

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
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 "Department," and CARELINK HEALTH PLANS, hereinafter referred to as the "Managed Care Organization."

WHEREAS, the Department has conducted an open solicitation for the services of Managed Care Organizations (MCOs) interested in entering into a contract to provide risk-based comprehensive health services to West Virginia Medicaid managed care recipients, and

WHEREAS, the Managed Care Organization (MCO) has demonstrated the ability to provide risk-based comprehensive health services in compliance with the program terms and requirements, and

WHEREAS, the Department has approved the MCO to provide risk-based comprehensive health services to West Virginia Medicaid managed care recipients,

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

1. GENERAL TERMS AND CONDITIONS

Written MCO responses to a Request for Applications (including the Department's written responses to oral and written questions, appendices, amendments, and addenda) and/or to other formal requests by the Department 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 precedent shall apply:

A. The terms of this contract

B. Written MCO responses to formal Department requests for information and documents, including responses, supplemental responses, and clarifications of responses to a Request for Applications

In construing this contract, whenever appropriate, the singular tense shall 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 shall not be construed to be a part of this contract.

2. CONTRACT TERM

The initial term of this contract shall commence on July 1, 2011 and shall be effective through June 30, 2012 at which time the contract may be renewed, at the option of the Department, for two successive one-year periods or until such "reasonable time" thereafter as is necessary to obtain a new contract or renew the original contract. The "reasonable time" period shall not exceed 12 months. The contract shall automatically extend for six additional months if, on the ending date of the contract, the MCO and the Department are engaged in good faith renegotiations of this contract or negotiation of another risk-based contract. Department capitation payments to the MCO will apply to the time period July 1, 2011 through June 30, 2012. Should the contract be extended for six additional months, capitation payments for the six additional months will be actuarially sound. Notice by the MCO of intent to terminate the contract will not relieve the MCO of the obligation to provide services pursuant to the terms of the contract.

In the event the Department opts to extend the contract, notice shall be sent to the MCO 90 days prior to the end of the base contract period. In the event a decision is made not to extend the contract, notice shall also be sent to the MCO 90 days prior to the end of the base contract period.

Any renegotiation of this contract will occur as follows:

- For good cause, only at the end of the contract period; and
- For modifications during the contract period, if circumstances warrant, at the discretion of the State.

3. ENTIRE AGREEMENT

This contract constitutes the entire agreement between the parties. No amendment or other modification changing this contract shall 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 shall be administered for the State by the Bureau for Medical Services within the Department of Health and Human Resources. The Commissioner of the Bureau for Medical Services or his/her designees shall serve as Contracting Officer upon the execution of the contract. The Contracting Officer shall be responsible for all matters related to this contract.

5. NOTICES

Any notice required under this contract shall be deemed sufficiently given upon delivery, if delivered by hand (signed receipt obtained) or 3 days after posting if properly addressed and sent certified mail return receipt requested. Notices shall be addressed as follows:

Managed Care Organization

Carelink Health Plans
500 Virginia St., East
Suite 400
Charleston, WV 25301

Department

Nancy Atkins, Commissioner
Bureau for Medical Services
350 Capitol Street
Charleston, West Virginia 25301

Said notices shall become effective on the date of receipt or the date specified within the notice, whichever comes later. Either party shall be notified of an address change in writing.

All questions, requests, and other matters related to the administration of this contract must be addressed with Brandy Pierce to be considered. Ms. Pierce's contact information is below.

Brandy J. Pierce, Director of Managed
Care and Procurement Services
Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, West Virginia 25301
(304) 558-1706
Brandy.J.Pierce@wv.gov

ARTICLE II: GENERAL CONTRACT TERMS FOR MANAGED CARE ORGANIZATIONS

1. DEFINITIONS

As used throughout this contract, the following terms shall 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.

Action – 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 reduction, suspension, or termination of a previously authorized service; the MCO's failure to provide services in a timely manner; 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.

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

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 the Department to provide assistance in this project or any other project.

Capitation Payment - A method of payment in which a health plan, such as an MCO or a specific health care provider, receives a fixed amount for each person eligible to receive services (dollars per member per month), which is made whether or not the covered person becomes an active patient and without regard to the number and mix of services used by that patient.

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.

Complaint – an expression of dissatisfaction made about an MCO decision or services received from the MCO when an informal grievance is filed; some complaints may be subject to appeal.

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

Contract Services - those services which the MCO is required to provide under this contract.

CMS - the Centers for Medicare and Medicaid Services, a division within the federal Department of Health and Human Services.
Department - the Department of Health and Human Resources, State of West Virginia.

Day - Except where the term "working days" is expressly used, all references in this contract will be construed as calendar days.

DHHS - the United States Department of Health and Human Services.

Eligible Recipient or Recipient - a person who receives Medicaid in accordance with the State Plan.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) – medically necessary services, including interperiodic and periodic screenings, listed in section 1905(a) of the Social Security Act.

Emergency Care - includes inpatient and outpatient services needed immediately and provided by a qualified Medicaid provider for emergency medical conditions where the presenting symptoms are of sufficient severity that a person with average knowledge of health and medicine would reasonably expect the absence of immediate medical attention to result in placing their health or the health of an unborn child in immediate jeopardy, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part; and that are needed to evaluate or stabilize an emergency medical condition. These include accidental injury and poison related problems and complaints that may be indicative of serious, life threatening medical problems, such as chest or abdominal pain, difficulty breathing or swallowing, or loss of consciousness. If the patient presents at the hospital emergency department and requests an examination, a nurse triage screening is always allowed.

Emergency Medical Condition – conditions where the presenting symptoms are of sufficient severity that a person with average knowledge of health and medicine would reasonably expect the absence of immediate medical attention to result in placing the individual's health or the health of an unborn child in immediate jeopardy, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part.

Encounter Data - procedure-level data on each contact between an enrolled individual and the health care system for a health care service or set of services included in the covered services under the contract.

Enrollee - a Medicaid recipient who has been certified by the State as eligible to enroll under this contract, and whose name appears on the MCO enrollment information which the Department will transmit to the MCO every month in accordance with an established notification schedule. An enrollee is also referred to as a member.

External Quality Review Organization (EQRO) - the entity contracted by the Department to conduct periodic independent studies regarding the quality of care delivered to West Virginia Medicaid managed care enrollees.

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

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.

Formal Grievance – a written expression of dissatisfaction other than those subject to appeal.

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.

Grievance – an expression of dissatisfaction, either in writing (formal) or orally (informal), regarding any aspect of service delivery provided or paid for by the MCO, other than those MCO actions that are subject to appeal. The term grievance also refers to the overall system that includes grievances and appeals handled at the MCO level and access to the State fair hearing process.

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.

Informal Grievance – an oral expression of dissatisfaction other than those subject to appeal.

Key Personnel - the MCO's Chief Executive Officer, Department Managers, and other staff specifically named in the application for certification.

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) – a Health Maintenance Organization licensed to do business in the State of West Virginia, which is the contractor providing services under this contract.

Medically Necessary – 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, for the prevention of illness, or to achieve age-appropriate growth and development.

Medicaid - the West Virginia Medical Assistance Program operated by the Department under Title XIX of the Federal Social Security Act, 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.

Mountain Health Choices – the benchmark benefit plan allowed by the Deficit Reduction Act of 2005 that allows West Virginia Medicaid to provide alternative benefit packages to selected children and adults. Mountain Health Choices offers basic and enhanced benefit packages. Members can receive the enhanced benefit package by signing a Member Agreement and agreeing to a Health Improvement Plan with their PCP. Mountain Health Choices was created through a State Plan Amendment and approved by CMS on May 3, 2006.

Patient-Centered Medical Home – "a health care setting that facilitates partnerships between individual patients and their personal physicians and, when appropriate, the patients' families and communities. A patient-centered medical home integrates patients as active participants in their own health and well-being. Patients are cared for by a physician or physician practice that leads a multidisciplinary health team, which may include, but is not limited to, nurse practitioners, nurses, physician's assistants, behavioral health providers, pharmacists, social workers, physical therapists, dental and eye care providers and dieticians to meet the needs of the patient in all aspects of preventive, acute, chronic care and end-of-life care using evidence-based medicine and technology. At the point in time that the Center for Medicare and Medicaid Services includes the nurse practitioner as a leader of the multidisciplinary health team, this state will automatically implement this change (§16-29 H-9 of the West Virginia State Code)."

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 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.

Primary Care Provider (PCP) - a specific clinician responsible for coordinating the health care needs of certain enrollees.

Provider - a health care provider who meets the requirements of the West Virginia Medicaid Program and is a member of the MCO's network.

Prior Authorization - 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 recipient.

Recipient - see Eligible Recipient.

Regulation - a Federal or State agency statement of general applicability designed to implement or interpret law, policy, or procedure.

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 the Department.

Service Authorization – see Prior Authorization; includes an enrollee's request for the provision of a service.

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.

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).

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 Bureau for Medical Services within the Department of Health and Human Resources is the single state agency responsible for administering the Medicaid program. No delegation by either party in administering this contract shall 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

The Department will determine the initial and ongoing eligibility for medical assistance of each enrollee or potential enrollee under this contract.

4.2 Enrollment

The Department, either directly or through its subcontractors, will process all enrollments into the MCO. The Department will notify the 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 magnetic tape or other electronic media, and will be delivered by the Department to the MCO as soon as possible following the MMIS cut-off date for the month, but not later than the last working day before the end of the month. Final and second cut-off dates for enrollment rosters will be provided to the MCOs by December 31st of each year.

4.3 Voluntary and Involuntary Disenrollment

All MCO enrollees will remain continuously enrolled throughout the term of this contract, except in situations where clients change MCOs or from a MCO to an alternative system (e.g., PAAS) in certain geographic areas of the managed care initiative, lose their Medicaid eligibility, are admitted to a skilled nursing facility (SNF) or nursing facility, or are recategorized into a Medicaid coverage category not included in the managed care initiative.

The Department 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).

4.4 Capitation Payments to Managed Care Organization

Payment to the MCO shall be based on the enrollment data transmitted from the Department to its fiscal agent each month, and upon the monthly claims invoices submitted by the MCO to the fiscal agent. The fiscal agent will reconcile these data, and will not pay a capitation on behalf of clients who appear on only one of the two sources. The MCO will be responsible for detecting the source of the inconsistency. The MCO shall notify the Department of any inconsistency between enrollment and payment data. The Department agrees to provide to the MCO information needed to determine the source of the inconsistency within ten working days after receiving written notice of the request to furnish such information. The Department will recoup overpayments or reimburse underpayments. The adjusted payment (representing reinstated recipients) for each month of coverage shall 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 the Department.

In full consideration of contract services rendered by the MCO, the Department agrees to pay the MCO monthly payments based on the methodology specified in Exhibit B. Department capitation payments to the MCO will apply to the time period July 1, 2011 through June 30, 2012 (State Fiscal Year 2012). State Fiscal Year 2013 capitation payments will be determined by the Department no later than March 15, 2012. If the Department does not publish the capitation

rates by March 15, 2012, and the MCO decides not to renew the contract with the Department for the subsequent State Fiscal Year such that the Department cannot be given 90 days written notice, the MCO and the Department will mutually agree to the effective date for termination. All other termination provisions would apply.

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 the Department.

Except for emergency services, no payment will be made for services furnished by a provider other than the MCO, if the services were available under the contract.

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 under 42 CFR 438.730.
The Department 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. The Department reserves the right to change the payment process, but the payment timing described above will remain the same.

4.5 Retrospective Capitation Adjustments

Changes in recipient eligibility categories which become known subsequent to payment of a capitation payment shall not relieve the MCO of liability for provision of care for the period for which capitation payment has been made.

The MCO agrees to 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. The Department will make every effort to ensure that only those Medicaid recipients eligible for enrollment are enrolled.

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

4.6 Reinstatement Processing

Medicaid recipients who lose eligibility for the West Virginia Mountain Health Trust program and regain eligibility within 60 days will be automatically re-enrolled in the same MCO in which they were previously enrolled, unless the recipient chooses another MCO. The Department 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 60 days, the recipient will be permitted to select a MCO through the standard enrollment broker enrollment process.

4.7 Information

The Department will make available to each MCO complete and current information which relates to pertinent statutes, regulations, policies, procedures, and guidelines affecting the operation of this contract. This information shall be available either through direct transmission to the MCO or maintenance of public resource files accessible to MCO personnel.

The Department will notify each MCO in writing of any exclusion initiated by DHHR for a fee-for-service Medicaid provider so that the MCO can exclude that provider from its network. The Department will also inform each MCO in writing of how to access debarred and OIG sanction information on the Internet.

4.8 Ongoing Managed Care Organization Monitoring

To ensure the quality of care, the Department will undertake the following monitoring activities:

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 subcontracted providers.
2. Conduct regular recipient surveys addressing issues such as satisfaction and reasons for disenrollment.
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 audits will take place at least once per year. The Department or its contractors must provide to the MCO summaries, at the Department's expense, of all monitoring activity reports, surveys, audits, studies, reviews, and analyses.

4.9 Utilization Review and Control

The Department shall waive, to the extent allowed by law, any current Department fee-for-service requirements for prior authorization, second opinions, copayment, or other Medicaid restrictions for the provision of those contract services provided by the MCO to enrollees.

4.10 Force Majeure

The MCO shall 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.

5. DECLARATIONS AND MISCELLANEOUS PROVISIONS

5.1 Competition Not Restricted

In signing this Agreement, the MCO asserts that no attempt has been made or will be made by the MCO to induce any other person or firm to submit or not to submit a proposal for the purpose of restricting competition.

5.2 Binding Authority

Each MCO representative signing the proposal must submit written certification 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).

5.4 Offer of Gratuities

The MCO shall warrant 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, the Department shall have the right to terminate this contract with 30 days 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 the Department, 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 recipients of assistance through the Department, 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 shall be regarded as confidential information and all necessary steps shall be taken by the MCO to safeguard the confidentiality of such material or information in conformance with federal and state statutes and regulations.

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

5.8 Independent Capacity

The MCO, its officers, employees, subcontractors, or any other agent of the MCO in performance of this Agreement will act in an independent capacity and shall not hold themselves out to be officers or employees of the State of West Virginia or of the Department.

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.

Ms. Brandy Pierce shall serve as the Department's liaison.

5.10 Key Staff Positions

The MCO shall provide the Department with an organizational chart depicting the key staff positions in the Medicaid line of business by October 1 of each contract year. The organizational chart shall include the names, titles, and contact information for the following key staff positions or functions: Contract Liaison/Medicaid Administrator, Chief Financial Officer, Medical Director, Medical Management (Utilization Review/Care Management) Director, Quality Director, Member Services Director, Claims Payment Director, Provider Relations Director, and Information Technology Director. The MCO shall notify the Department in writing of changes in key staff positions within 14 calendar days of any change. The MCO shall also provide an updated organizational chart within 14 calendar days of any change. These changes shall be reported when individuals either leave or fill these key positions.

The Medical Director and the Director of Medical Management, or designee, must respond to requests of the Department's Medical Director or Contract Administrator within three business days.

5.11 Location of Operations

The MCO shall notify the Department 45 days in advance of any proposal to modify claims operations and processing, member services, or case management processes that shall include the relocation of operations.

5.12 Responsiveness to the Department

The MCO shall acknowledge receipt of the Department's written, electronic, or telephonic requests as expeditiously as the matter requires or no later than two business days after receipt of the request from the Department. The MCO's acknowledgment must include a planned date of resolution. A detailed resolution summary advising the Department of the MCO's action and resolution shall be rendered to the Department in the format requested.

The Department's urgent requests for assistance such as issues involving legislators, other governmental bodies, or as determined by the Department, must be given priority by the MCO and completed in accordance with the request of and instructions from the Department. The Department shall provide guidance with respect to any necessary deadlines or other requirements. A resolution summary, as described by the Department, shall be submitted to the Department.

5.13 Freedom of Information

Due regard will be given for the protection of proprietary information contained in all applications and documents received; however, bidders should be aware that all materials associated with the procurement 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 MCOs 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 a Bidder believes to proprietary must be specifically identified as such. Convincing explanation and rationale sufficient to justify each exemption from release consistent with West Virginia Code 29.B-1-1 et seq. must accompany the documents. The rationale and explanation must be stated in terms of the prospective harm to the MCO's competitive position that would result if the identified material were to be released and the reasons why the materials are legally exempt from release pursuant to the above cited statute. Between the MCO and the Department the final administrative authority to release or exempt any or all material so identified rests with the Department.

5.14 Waivers

No covenant, condition, duty or obligation, or undertaking contained in or made a part of this contract shall be waived except by the written agreement of the parties.

5.15 Compliance With Applicable Laws, Rules, And Policies

The MCO, in performing this contract, shall 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 shall include provisions relating to compliance with such laws in subcontracts with providers. Assessment of compliance should 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 shall 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 abusers;
- 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 438of the Code of Federal Regulations, pertaining to managed care;
- Section 29a of the West Virginia Code;
- 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; and
- Any other pertinent Federal, State or local laws, regulations, or policies in the performance of this contract.

The MCO shall 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 shall report to DHHR any data necessary in order for DHHR to comply with the program integrity and drug rebate provisions set forth in PPACA and HCERA, including the collection of National Drug Codes (NDC) on physician-administered drugs (e.g., J-code services).

The MCO shall 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 shall 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 shall retain at all times during the period of this contract a valid Certificate of Authority issued by the State Commissioner of Insurance.

The MCO shall 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 shall be born by the MCO.

The MCO shall adhere to the provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA) Public Law 100-578.

5.16 Non-discrimination

The MCO shall comply with all Federal and State laws relating to non-discrimination and equal employment opportunity and with the Civil Rights Act of 1964 (78 Stat 252), regulations issued pursuant to those laws, and the provisions of Executive Order 11246 dated September 26, 1965 related to Equal Employment Opportunity. The MCO shall not use any policy or practice that has the effect of discriminating by race, ethnicity, color, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.

The MCO will not discriminate in enrollment, delivery of health care, or any other activity against enrollees on the basis of health status, conditions of or type of enrollment in the geographic areas within the managed care initiative, or need for health care services.

5.17 Federal Requirements and Assurances

The MCO shall 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 the Department.

The MCO shall provide for the compliance of any subcontractors with applicable federal requirements and assurances.

5.18 Lobbying

The MCO, as provided by 31 U.S.C. 1352 and 45 CFR 93.100 et seq., shall 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 shall submit to the Department a disclosure form as provided in 45 CFR 93.110 and Appendix B 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 shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall 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 shall be subject to a civil penalty.

5.19 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 shall make the information reported available to its enrollees upon reasonable request.

The MCO shall covenant that it, its officers or members, employees, or subcontractors shall 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 shall periodically inquire of its officers, members, and employees concerning such interests. Any such interests discovered shall be promptly presented in detail to the Department.

5.20 Department's Data Files

The Department's data files and data contained therein shall be and remain the Department's property and shall be returned to the Department by the MCO upon the termination of this agreement at the Department's request, except that any Department data files no longer required by the MCO to render services under this contract shall be returned upon such determination at the Department's request.

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

The Department shall, 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 shall establish and maintain at all times reasonable safeguards against the destruction, loss, or alteration of the Department's data and any other data in the possession of the MCO necessary to the performance of operations under this contract.

5.21 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 the Department.

5.22 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 41 U.S.C. 423.

6. CORRECTIVE ACTION AND CONTRACT TERMINATION

6.1 Performance Review

A designated representative of the MCO and a designated representative of the Department shall meet as requested by either party, to review the performance of the MCO under this contract. Written minutes of such meetings shall be kept. In the event of any disagreement regarding the performance of services by the MCO under this contract, the designated representatives shall discuss the problem and shall negotiate in good faith in an effort to resolve the disagreement.

The Contracting Officer shall provide the Contractor with written notice of conditions endangering performance (e.g., violations, deficiencies). Conditions that endanger performance include, but are not limited to, the following:

- Failure to substantially provide medically necessary items and services that are required (under law or under the MCO's contract with the Department) to be provided to an enrollee covered under the contract;
- Imposing premiums or charges enrollees in excess of the premiums or charges permitted under Title XIX, or engaging in any practice that discriminates on the basis of health status or need for health care services;
- Misrepresenting or falsifying information furnished to the Department, 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.

If the MCO is found to perform any of the above activities the Department must notify the CMS Regional Office.

Unless otherwise specified in the written notice of condition(s) that endanger performance, the Department shall allow the MCO a minimum of ten working days to remedy the condition(s) contained in the notice. If after such notice of conditions that endanger performance the Contractor fails to remedy the conditions contained in the notice, within ten working days or the time period specified in the notice, the matter shall be referred to the Contracting Officer as provided under Section 6.2, Sanctions of this contract. If the Contracting Officer determines that the MCO has failed to perform as measured against applicable contract provisions, the Contracting Officer may then terminate this contract in whole or in part, as provided under Section 6.8 Termination for Default clause.

6.2 Sanctions

The State may impose sanctions if it determines that an MCO acts or fails to act in the following ways, based on findings from onsite surveys, enrollee or other complaints, financial status, or any other source:

- Fails substantially to provide medically necessary services that the MCO is required to provide, under law or under its contract with the State, to an enrollee covered under the contract;
- Imposes on enrollees premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program;
- Acts to discriminate among enrollees on the basis of their health status or need for health care services, including termination of enrollment or refusal to reenroll a recipient, except as permitted under the Medicaid 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;
- Misrepresents or falsifies information that it furnishes to CMS or to the State;

- Misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider;
- Distributes 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; or
- Has violated any of the other requirements of sections 1903(m) or 1932 of the Social Security Act, and any implementing regulations.

Additional sanctions that may be imposed at the Department's or CMS's recommendation include the following:

- A letter notifying the MCO of condition(s) that endanger performance that will be maintained in the Department's permanent records on the MCO's performance;
- Suspension of further enrollments, except newborns and autoreenrollments;
- Retention of a portion of capitation payments by the Department until the MCO corrects violations/deficiencies subject to, and in accordance with, Section 6.6, Withholding of Payment and Section 6.7, Disputes and Appeals of this contract;
- Daily financial penalties until the MCO corrects violations/deficiencies, subject to and in accordance with Section 6.4, Financial Penalties and Section 6.7, Disputes and Appeals of this contract;
- Nonrenewal of the contract between the Department and the MCO at the renewal date; or
- Termination of the contract between the Department and the MCO.

If the State imposes the additional sanction of temporary management as set forth in 42 CFR 438.706(b) because the State has determined 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 Department of Insurance shall be responsible for the imposition of such a sanction as set forth in Section 33-25A-19 of the West Virginia HMO Act of 1977. If such a sanction is imposed, the State shall notify enrollees of their right to terminate enrollment in the MCO.

In addition to the reasons previously outlined, the State may terminate an MCO contract and enroll that entity's enrollees in other MCOs or PCCM, or provide their Medicaid benefits through other options included in the State Plan, if the State determines that the MCO has failed to carry out the substantive terms of its contract, or meet applicable requirements in sections 1932, 1903(m) and 1905(t) of the Social Security Act.

Nothing precludes the Department's right to issue a sanction 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 such sanction is imposed, the Department will notify, in writing, the MCO of the alleged specific deficiency. Within ten working days of receipt of this written notification, the MCO will forward a plan to remedy this deficiency to the Department. The Department 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 deficiency in accordance with the plan, and will have 15 working days to do so. If the plan is not accepted, such reasons shall be given, and the MCO will revise the plan to reflect the Department's changes, and then will resubmit and then will immediately begin to remedy the deficiency and will have 15 working days to do so.

6.3 Emergency Services Denials

MCOs that have a pattern of inappropriately denying payments for emergency-related services may be subject to suspension of new enrollments, withholding of a portion of capitation payments subject to Section 6.2, Sanctions, Section 6.6, Withholding of Payments, and Section 6.7, Disputes and Appeals of this contract, contract termination, or refusal to contract in a future time period. MCOs have the right to appeal as specified under Section 6.7 Disputes and Appeals. This applies not only to cases where the Department has ordered payment after appeal, but also to cases where no appeal has been made.

6.4 Financial Penalties

If an MCO does not submit a required report, data certification form, or data required to meet federal reporting requirements (e.g., drug utilization data, provider-preventable conditions) to the Department within the timeframes outlined in this contract, the Department may exercise the option to impose daily financial penalties on the MCO. The MCO shall have a one business day grace period following the due date of the data, report, or form. However, for each additional day these items are overdue, the Department may impose a financial penalty of $250 per calendar day, per item, until the submission of the report, data certification form, or data required to meet federal reporting requirements.

6.5 Suspension of New Enrollment

Whenever the Department determines that the MCO is out of compliance with this contract, the Department may suspend enrollment of new enrollees under this contract. The Department, when exercising this option, must notify the MCO in writing of its intent to suspend new enrollment at least ten working days prior to the beginning of the suspension period. The suspension period may be for any length of time specified by the Department, or may be indefinite. The suspension period may extend up to the contract expiration date as provided under Article I. (The Department may also notify existing enrollees of the MCO non-compliance and provide an opportunity to disenroll from the MCO and to re-enroll in another MCO.)

6.6 Withholding of Payments

Notwithstanding the payment provisions elsewhere in this contract, the Department may withhold portions of capitation payments from the MCO as provided here. Whenever the Department determines that the MCO has failed to provide one or more of the medically necessary contract services required, the Department may withhold an estimated portion of the MCO's capitation payment in subsequent months, such withhold to be equal to the amount of money the Department expects to pay for such services, plus any administrative costs involved. The MCO shall not elect to withhold any required services in order to receive adjusted payment levels. The MCO shall be given at least ten working days written notice prior to the withholding of any capitation payment.

When it withholds payments under this section, the Department must submit to the MCO a list of the participants for whom payment is being withheld, the nature of service(s) denied, and payments the Department must make to provide medically necessary services. When all payments have been made by the Department for the MCO contracted services, the Department will reconcile the estimated withhold against actual payments.

The Department may also adjust payment levels accordingly if the MCO has failed to maintain or make available any records or reports required under this contract which the Department needs to determine whether the MCO is providing required contract services. The MCO will be given at least ten working days notice prior to taking any action set forth in this paragraph. Nothing precludes the Department's right to issue a sanction, in accordance with Section 6.2 Sanctions and Section 6.7 Disputes and Appeals of this contract, while an appeal filed by the MCO is pending.

6.7 Disputes and Appeals

This contract is not subject to arbitration. Any dispute concerning performance of this contract shall be decided by the Contracting Officer who shall put his/her decision in writing within ten working days and serve a copy on the MCO and Department. The Contracting Officer's decision shall be final unless within ten working days of the receipt of such copy, the MCO or Department files with the Contracting Officer a written appeal.

The Contracting Officer shall issue his/her recommended course of action to the Commissioner, Bureau for Medical Services. The Commissioner, Bureau for Medical Services will review the Contracting Officer's recommendation and issue a decision.

Should the MCO disagree with the decision, the MCO can request a hearing before an administrative law judge, who shall take evidence and hear oral argument. In connection with any appeal proceeding under this subsection, the MCO shall be afforded an opportunity to be heard and to offer evidence and oral argument in support of its appeal. At such hearing, the Department shall also offer evidence and oral argument in support of its position.

The administrative law judge, who will serve as an impartial fact finder, shall issue a proposed decision to the MCO and to the Department within 60 days of the end of the hearing. The MCO and the Department shall have ten working days after the mailing of the proposed decision to request a review. If such a request is made, the Secretary, Department of Health and Human

Resources shall, thereafter, issue a final decision. There shall be no ex parte communications with the administrative law judge during pendency of the appeal. In any appeal process, there shall be delivered to the administrative law judge copies of all pleadings or other documents being filed in connection with the appeal. The reasonable costs of an administrative appeal including costs of reporting and preparing a transcript will be paid by the party appealing. Such decision shall be final except to the extent that the MCO appeals to the Circuit Court of West Virginia. The pendency of an appeal to the Secretary or the Circuit Court shall not automatically stay any notice of termination which may be appealable.

Pending final determination of any dispute, the MCO shall 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 shall be deemed a waiver of any claim which the MCO might have had.

6.8 Termination For Default

The Department may terminate performance of work under this contract in whole, or in part, whenever the MCO shall default in performance of this contract and shall fail to cure such default or make progress satisfactory to the Department toward contract performance within a period of 30 days after receipt of notice of default (or such longer period as the Department may allow). Such termination shall be referred to herein as "Termination for Default."

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 shall be deemed to have been issued as a termination for the convenience of the Department, and the rights and obligations of the parties shall be governed accordingly.

In the event the Department terminates the contract in full or in part as provided in this clause, the Department may procure services similar to those terminated, and the MCO shall be liable to the Department 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. In addition, the MCO shall be liable to the Department for administrative costs incurred by the Department in procuring such similar services. Provided, however, that the MCO shall not be liable for any excess costs or administrative costs if the failure to perform the contract arises out of causes beyond the control and without error or negligence of the MCO or any of its subcontractors.

Prior to the termination for default of the MCO, the Department may take the following steps:

- After a hearing before the administrative law judge, if one is requested by the MCO as set forth in Section 6.7, 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 shall 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 written notification to the Department, whenever the Department shall fail to make payment for services under this contract for 60 days and shall fail to cure such non-payment or make progress toward curing nonpayment within a period of 30 days after receipt of the MCO's written notice of termination.

The rights and remedies of the Department provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or under this contract.

6.9 Termination for Convenience

The Department or the MCO may terminate this contract at any time with at least 90 days written notice. The effective date must be the first day of a month. The MCO shall be paid the following:

1. At the contract price(s) for services delivered to and accepted by the Department.
2. At a price mutually agreed to by the MCO and the Department for services partially completed.

If the MCO terminates this contract for convenience, the MCO shall not be permitted to reapply for participation in the Mountain Health Trust program for a period of not less than one year, or such time period determined by BMS, at the discretion of BMS.

6.10 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, shall be viewed as binding and shall 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 of either party to the other party at least 30 days prior to termination.

6.11 Termination for Managed Care Organization Bankruptcy

In the event of the filing of a petition in bankruptcy by or against the MCO, the Department shall have the right to terminate the contract upon the same terms and conditions as a Termination for Default.

6.12 Termination for Unavailability of Funds

The Department 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 30 days notification of termination.

After modification of the contract, the MCO shall 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 shall have a minimum of 60 days to notify the Department regarding its desire to accept new terms. If the new capitation rates and any other contract modifications are not established at least 60 days prior to the expiration of the initial or extension agreement, the Department 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 60-day determination and notification period had not been completed, and the MCO will be held to the terms of the executed contract.

If the Department is not allotted funds in any succeeding fiscal year for the continued use of the services covered by this contract, the Department may terminate the contract pursuant to Section 6.12 hereof at the end of the affected current fiscal period without further charge or penalty. The Department shall be obligated to pay all charges incurred through the end of the then fiscal year at which time this contract shall terminate. The Department shall give the MCO written notice of such non-allocation of funds as soon as possible after the Department receives notice of such non-allocation. No penalty shall accrue to the Department in the event this provision is exercised.

6.13 Termination Obligations of Contracting Parties

Upon contract termination, the MCO shall allow the Department, its agents and representatives full access to the MCO's 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 shall no longer accept new enrollees. The MCO shall 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 shall 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 shall provide BMS with the names and treatment plans of enrollees with such plans.

Upon contract termination, the MCO shall 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 shall be submitted no later than 90 days after the end of the quarter in which the encounters occurred. BMS may request an interim encounter data submission 90 days after the termination of the contract.

Where this contract is terminated due to default by the MCO:

- The Department shall 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 shall be responsible for all reasonable expenses related to said notification.

Where this contract is terminated for any reason other than default by the MCO:

- The Department shall be responsible for notifying all enrollees of the date of termination and process by which the enrollees will continue to receive services; and
- The Department shall be responsible for all expenses relating to said notification.

6.14 Waiver of Default or Breach

Waiver of any default shall not be deemed to be a waiver of any subsequent default. Waiver of breach of any provision of the contract shall not be deemed to be a waiver of any other or subsequent breach and shall 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 the Department and the MCO, and attached to the original contract.

6.15 Severability

If any provision of this contract is declared or found to be illegal, unenforceable, or void, then both parties shall be relieved of all obligations under that provision. The remainder of this contract shall be enforced to the fullest extent permitted by law.

7. OTHER REQUIREMENTS

7.1 Inspection of Facilities

The MCO shall provide the State of West Virginia and any other legally authorized governmental entity, or their authorized representatives, the right to enter at all reasonable times the MCO's premises 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 MCO shall 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 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 subcontractor shall 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 shall be conducted in a manner as will not unduly interfere with the performance of the MCO's or any subcontractors activities. The MCO shall be given ten working days to respond to any findings of an audit before BMS shall finalize its findings. All information so obtained will be accorded confidential treatment as provided under applicable law.

7.2 Maintenance and Examination of Records

The MCO must maintain books and records relating 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 agree to permit inspection of its records, which will be conducted in accordance with Federal and State laws and regulations regarding confidentiality. The MCO will be required to submit information to BMS in a manner that maintains the confidentiality of involved parties (e.g., blacking out members' and providers' names). The MCO shall 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 member and provider quality assurance and quality improvement records when confidentiality is protected by law, are the property of BMS.

Upon non-renewal or termination of this contract, the MCO shall turn over or provide copies to BMS or to a designee of BMS all documents, files and records relating to persons receiving services and to the administration of this contract that BMS may request. This provision does not apply to patient medical records.

The MCO shall provide BMS and its authorized agents with reasonable access to records the MCO maintains for the purposes of this contract. BMS and its authorized agents will request access in writing except in cases of suspected fraud and abuse. The MCO must make all

requested medical records available within ten working days of BMS' request. Any contract with an approved subcontract must include a provision specifically authorizing access in accordance with the terms set forth in this paragraph.

7.3 Audit Accounting and Retention of Records

The MCO, for purposes of audit, shall provide the State of West Virginia, the Secretary of the U.S. Department of Health and Human Services and his/her designated agent, and any other legally authorized governmental entity or their authorized agents access to all the MCO's materials and information pertinent to the services provided under this contract, at any time, until the expiration of five years from the completion date of this contract as extended. 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 verify the cost of services rendered under this contract.

The MCO shall agree that authorized State representatives including, but not limited to, Department personnel, the State Auditor and other State and/or any applicable Federal agencies providing funds shall have access to and the right to examine the items listed above during the contract period and during the five 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 at all reasonable times. This may require the identification and collection of data for use by medical audit personnel. During the five year post-contract period, delivery of and access to the listed items will be at no cost to the State.
BMS may at its option conduct an audit of the MCO's operations as they pertain to services and recoveries pursuant to the contracted services.

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 member and provider quality assurance and quality improvement records when confidentiality is protected by law.

Accounting

The MCO will maintain accounting records relating to the performance of the contract. These accounting records shall be maintained in accordance with generally accepted accounting principles.

Separate Accounting Records

The MCO will maintain separate books, records, documents, and other evidence pertaining to the administrative costs and expenses of the contract to the extent and in such detail as shall properly reflect all revenues and all costs of whatever nature for which reimbursement is claimed under the provisions of the contract. All such documents shall be made available to BMS at its request, and shall be clearly identifiable as pertaining to the contract.

Retention of Records

All financial and programmatic records, supporting documents, statistical records and other records of enrollees, which are required to be maintained by the terms of this contract, shall be retained for at least five 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 five year period, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the regular five year period, whichever is later. The MCO must agree to retain the source records for its data reports for a minimum of five years and must have written policies and procedures for storing this information.

7.4 Subcontracts

The MCO may subcontract for any function covered by this contract, subject to the requirements 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 90 days prior to the effective date of the subcontract for BMS review and approval. Subcontracts shall fulfill the requirements of 42 CFR 434.6 and 42 CFR 438.230, and shall include any general requirements of this contract that are appropriate to the services being provided, and assure that all delegated duties of the MCO under this contract are performed. All subcontracts shall be in writing, shall include any general requirements of this contract that are appropriate to the services being provided, and shall assure that all delegated duties of the MCO under this contract are performed. Subcontracts shall not terminate legal liability of the MCO under 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) for good cause.

The MCO shall 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 shall not be construed to grant the MCO any right to such approval. This paragraph shall not be construed as restricting the MCO from entering into contracts with participating providers to provide health care services to plan enrollees.

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.

7.5 Insurance

The MCO, its successors and assignees shall procure and maintain such insurance as is required by currently applicable federal and state law and regulation. Such insurance should 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
5. Adequate reinsurance or a restricted fund balance for the purpose of self-insurance for financial risks accepted.

7.6 Disclosure of Ownership

By October 1 of each contract year, the MCO, as a "disclosing entity," must supply BMS with full and complete information, including the name and address of each person with an ownership or control interest in the MCO or the MCO's subcontractor in which the MCO has direct or indirect ownership of five percent or more. The MCO must supply BMS with information as to whether the person with ownership or control interest is related to any other person with ownership or control interest such as a spouse, parent, child, or sibling. The MCO must also supply 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, to the extent obtainable from the other organization by the MCO through written request. The MCO must immediately submit the above information to BMS as soon as its circumstances require the disclosure of ownership and control interest as required in 42 CFR 455.104. 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.

The MCO may not knowingly have a director, officer, partner, or person with beneficial ownership of more than five percent of the MCO's equity who has been debarred or suspended by any federal agency. The MCO is prohibited from having an employment, consulting, or any other agreement with a 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.

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, the MCO must collect information concerning the ownership and control interest of each contracted provider entity as well as managing employees1, as required in 42 CFR 455.104 and 455.105 and 455.106, including information on health care-related criminal offenses. MCOs shall make this information available to BMS upon request. The MCO have a process in place to verify information concerning ownership and control interest of the provider entities, including monthly monitoring of persons with ownership and control interests of network providers using HHS-OIG's List of Excluded Individuals/Entities or CMS' Medicare Exclusion Database.

[1] Definitions for each of these items can be found in 42 CFR §455.101.

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.

Federal regulations contained in 42 CFR 455.105 also require disclosure of information related to the business transactions of Medicaid providers. On October 1 of each contract year and at the request of BMS, the MCO must submit a report providing information concerning the business transactions of its contracted providers. The report must contain 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. SIGNATURES

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

West Virginia Department of Health and Human Resources

Signature: Nancy V. Atkins

Printed Name: Nancy V. Atkins

Title: BMS Commissioner

Date: 6/21/11

Carelink Health Plans

Signature: _____

Printed Name: John Muraca

Title: Vice President

Date: 6/7/11

ARTICLE III: STATEMENT OF WORK

1. COVERED SERVICES

1.1 Covered MCO Services

The MCO shall provide to enrollees enrolled under this contract, directly or through arrangements with others, all of the covered services described in Contract Exhibit A (Description of Covered and Excluded Services). Contract Exhibit 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 Exhibit 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 24 hours each day, seven 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.

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, 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 Exhibit A (Description of Covered and Excluded Services) through a capitation payment system. The MCO will be paid a fixed capitation rate per member per month (PMPM) and will not be permitted to collect any additional copayments or premiums from enrollees. Contract Exhibit B (Overview of West Virginia's SFY12 Mountain Health Trust Payment Methodology and Capitation Rates) contains a listing of the current capitation rates.

The MCO shall 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 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 Exhibit 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 fee-for-service 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

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 21. EPSDT services are included in the prepaid benefit package for children and adolescents up to age 21. The federal government, through the Centers for Medicare and Medicaid Services (CMS), requires states to demonstrate an 80 percent compliance rate for EPSDT screening schedules.

MCOs are required to:

1. Provide notification of screening due dates;
2. Perform the screenings according to the State-determined periodicity schedule;
3. Make the necessary referrals;
4. Track referrals and treatments;
5. Report the results via the encounter reporting system; and
6. Report results as necessary to meet federal requirements, as requested by BMS.

MCOs must have written policies and procedures for providing the full range of EPSDT services to all eligible children and young adults up to age 21. This information must be available for the hearing- and visually-impaired. Translation services should be made available as necessary. The full scope of EPSDT service requirements is described below.

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 reminders, follow-ups, and outreach to EPSDT service enrollees.

The MCO must inform all EPSDT eligible individuals (or their families) about the EPSDT program using clear and non-technical language. The MCO must meet the federal EPSDT informing requirements as specified in 42 CFR 441.56 and 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 statement that the services provided under the EPSDT program are without cost to eligible individuals under 21 years of age; and
4. A statement that necessary transportation and scheduling assistance is available to the EPSDT eligible individual upon request (non-emergency transportation is paid for fee-for-service by the State).

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, according to the American Academy of Pediatrics and Bright Futures Guidelines. These should be 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 medical and developmental history, including anticipatory guidelines/health education, nutrition assessment, developmental assessment (social, personal, language), and fine/gross motor skills;
2. An unclothed physical exam;
3. Laboratory tests;
4. Vision testing;
5. Hearing testing;
6. Dental screening (furnished by direct referral to a dentist for children beginning at three years of age);[2]
7. Blood lead testing; and
8. Behavioral health screening.[3]

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.

---

[2] The primary care provider (PCP) will provide dental screenings for children under three. Dentists will provide dental screenings for children three and over, and BMS will reimburse the dentists for these services on a fee-for-service basis; PCPs should refer children to dentists for these screenings.

[3] Behavioral health screenings do not include behavioral health services.

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 (these services will be paid for on a fee-for-service basis by BMS); and
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).

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 all follow-up diagnostic and treatment services deemed medically necessary to ameliorate or correct a problem discovered during an EPSDT screen. The MCO is responsible for determining if services are medically necessary.

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 shall 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 auspices of the Bureau for Public Health, the periodicity of preventive pediatric visits shall follow that recommended by the American Academy of Pediatrics or the accelerated visit schedule set for infants identified as "at risk" through the birth score system.
2. Preventive pediatric visits according to the American Academy of Pediatrics periodicity schedule up to age 21.
3. Diagnosis and/or treatment, or other referral in accordance with EPSDT screen results.

Report the Results

MCOs shall submit to BMS a report due 45 days after the end of each quarter which identifies its performance regarding EPSDT screening and referral rates, well-care child visit rates, dental visits, and immunization rates (see Section 5.11, Reporting Requirements).

Emergency Care

The MCO shall cover and pay for all medical services described in Contract Exhibit A that may be required on an emergency basis 24 hours each day, seven days a week, either in the MCO's

facilities or through arrangements approved by BMS.[4] The terms "emergency care," "urgent care," and "emergency medical conditions" are defined in Article II of this contract. Reimbursement for emergency services provided out-of-network must be equal to the Medicaid fee-for-service (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 pre-authorization is required to provide necessary medical care and enrollees may seek care from nonparticipating providers.

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 deny payment for treatment obtained when an enrollee had an emergency medical 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 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 should determine who pays for this care.

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.

The MCO shall not limit what constitutes an emergency medical condition on the basis of lists of diagnosis or symptoms.

Post-Stabilization Care

The MCO must cover and pay for post-stabilization services in accordance with the guidelines for coordinating post-stabilization care established under Medicare Part C at 42 CFR §422.113. Post-stabilization services are defined in Article II of this contract.

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

---

[4] Qualified medical personnel must be accessible 24 hours each day, seven 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.

not that provider or supplier contracts with the MCO to provide services covered by the MCO. Post-stabilization care services are covered services that:

- 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 hour after being requested to approve such care, or could not be contacted for pre-approval.

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.

Family Planning

Although family planning services are included within the MCO's list of covered benefits, Medicaid enrollees are entitled to obtain family planning services without prior authorization through any Medicaid provider, who will bill the MCO and be paid on a fee-for-service basis.[5] Family planning services are defined in Article II of this contract.

The MCO shall 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 shall 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 shall reimburse providers for all family planning services regardless of whether they are rendered by a participating or non-participating provider. Unless otherwise negotiated, the MCO shall 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 members. MCOs must also educate members regarding the positive impact of coordinated care on their health outcomes, so members will

---

[5] 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 shall not restrict the choice of the qualified person, from whom the individual may receive services under Section 1905(a)(4)(c)." Therefore, Medicaid recipients 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.

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 fee-for-service 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 shall 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 shall 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.

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

Maternity Services

Under the Newborns and Mothers Health Protection Act, the MCO may not:

- Limit benefits for postpartum hospital stays to less than 48 hours following a normal vaginal delivery or 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.

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 fee-for-service basis. Please see Exhibit A for a complete list of Medicaid-covered services that are excluded from the capitation rates, and additional details regarding these services.
Four Medicaid-covered services that are excluded from the capitation rates (non-emergency transportation, behavioral health services, children's dental, and outpatient pharmacy) have particular coordination requirements for MCOs, which are outlined below.

Non-emergency Transportation

Non-ambulance medical transportation to and from Medicaid covered scheduled medical appointments is covered by the fee-for-service Medicaid program. This includes transportation via multi-passenger van services and common carriers such as public railways, buses, cabs, and airlines, and private vehicle transportation by individuals. BMS must approve multi-passenger van services. Advance authorization by county DHHR staff is required for transportation by common carriers. The MCO must inform enrollees of how to access non-emergency transportation as appropriate.

Behavioral Health Services

All behavioral health services with the exception of services provided to children under age three (see Contract Exhibit A), will be provided on a fee-for-service basis.

Although the MCO is not responsible for providing the above services that will be provided through fee-for-service, the MCO's primary care provider (PCP) must coordinate behavioral health services, as appropriate, with the fee-for-service providers.

The PCP must maintain in an enrollee's medical record any information shared by the behavioral health provider as to the outcome of behavioral health screening and evaluation. The MCO is also responsible for facilitating the exchange of clinical information for Medicaid behavioral health services, upon request, among PCPs, and fee-for-service behavioral health providers to ensure care coordination.

Children's Dental

Emergency, surgical, diagnostic, preventive and restorative treatment, periodontics, endodontics, orthodontics, prosthodontics, extractions, and complete or partial dentures, when provided by a dentist, orthodontist, or oral surgeon, are covered for individuals under age 21 by fee-for-service Medicaid.

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 21, and prenatal vitamins) are covered by the fee-for-service Medicaid program. Hemophilia-related clotting factor drugs will be covered by the fee-for-service Medicaid program. MCO physicians may prescribe prescription drugs or other above-listed drugs and supplies to MCO enrollees, who may then fill the prescription at any pharmacy that accepts Medicaid by presenting their Medicaid card. Drugs and supplies dispensed by a physician acquired by the physician at no cost are not covered by fee-for-service Medicaid.

1.4 Non-covered Services

MCOs are not permitted to provide 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 Exhibit A.
5. Treatments for infertility[6] 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.
8. Christian Science nurses and sanitariums.

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

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

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.[7]

MCOs cannot impose any enrollee copayments or fees for contracted services. 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 shall be guilty of a felony and upon conviction shall be fined no more than $25,000 or imprisoned for no more than five years, or both.

1.6 Requirements Pertaining to Medicaid Redesign

The MCO must follow the benefit packages and policies of Mountain Health Choices. The Mountain Health Choices benefit packages for TANF and TANF-related adults and children are shown in Contract Exhibit A, MCO Covered Services for Mountain Health Choices Program. MCOs are responsible for reimbursing providers for a Health Risk Assessment Test as a part of the Mountain Health Choices benefit packages. The Health Risk Assessment Test is not subject to third party payment. Under Mountain Health Choices, MCO enrollees will receive the enhanced benefit package if they sign the West Virginia Medicaid Member Agreement and agree to a Health Improvement Plan with their PCP. Otherwise, MCO enrollees will receive the basic benefit package.

PCP Responsibilities Under Mountain Health Choices

PCPs under Mountain Health Choices will be the MCO enrollee's initial and most important contact with the MCO, as under Mountain Health Trust. The PCPs' responsibilities under Mountain Health Trust are outlined in Article III, Section 2.2 of the contract.

According to West Virginia State Code 16-29 H-9, a patient-centered medical home is, "a health care setting that facilitates partnerships between individual patients and their personal physicians and, when appropriate, the patients' families and communities. A patient-centered medical home integrates patients as active participants in their own health and well-being. Patients are cared for by a physician or physician practice that leads a multidisciplinary health team, which may include, but is not limited to, nurse practitioners, nurses, physician's assistants, behavioral health providers, pharmacists, social workers, physical therapists, dental and eye care providers and dieticians to meet the needs of the patient in all aspects of preventive, acute, chronic care and end-of-life care using evidence-based medicine and technology. At the point in time that the Center for Medicare and Medicaid Services includes

---

[7] 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.

the nurse practitioner as a leader of the multidisciplinary health team, this state will automatically implement this change."

2. PROVIDER NETWORK

2.1 General Requirements

Network Capable of Full Array of Services

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), and specialty care providers in sufficient numbers to make available all covered services in a timely manner. The MCO shall maintain a sufficient number, mix, and geographic distribution of providers.

The MCO must contract with sufficient numbers of providers to maintain sufficient access in accordance with BMS' Medicaid managed care network standards. The MCO must submit written documentation of the adequacy of its provider network as set forth in this contract, at the time the MCO enters into a contract with BMS; when there has been a significant change in MCO operations; when services, benefits, geographic service areas, or payments have been changed; or there is enrollment of a new population in the MCO.

The MCO must contract with the full array of providers necessary to deliver a level of care that is at least equal to the community norms and meet the travel time, appointment scheduling, and waiting time standards included in this contract.

The MCO must maintain and monitor a network of appropriate, credentialed providers, supported by written arrangements, that is sufficient to provide adequate access (as defined by BMS) to covered services and to meet the needs of the population served. In establishing and maintaining the network, the MCO shall 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.

Availability and Access Standards

This network must include a panel of primary care providers from which the enrollee may select a personal primary care provider. Requirements for adequate access state that:

- Routinely used delivery sites, including PCPs' offices and the offices of frequently used specialists, must be located within 30 minutes travel time;
- Basic hospital services must be located within 45 minutes travel time; and
- Tertiary services must be located within 60 minutes travel time.

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 "frequently used specialists" in each county or region, based on a comparison to the traditional Medicaid program or other criteria as defined by BMS. Exceptions to these standards will be permitted where the travel time standard is better than what exists in the community at large. For example if the community standard for basic hospital services is 60 minutes travel time, then the MCO's basic hospital service must be located within 60 minutes travel time (not within 45 minutes travel time). MCOs will be required to comply with updated network standards within 90 days of issuance, unless otherwise agreed to in writing by BMS within 60 days of issuance.

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 fee-for-service. 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).

When medically necessary, the MCO makes services available 24 hours a day, seven days a week. The MCO must establish a mechanism to ensure that providers comply with the access standards set forth in this contract. The MCO should regularly measure the extent to which providers in the network comply with these requirements and take remedial action if necessary. 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.

The MCO must have standards for timeliness of access to care and member 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. 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[8] state that:

- Emergency cases must be seen immediately or referred to an emergency facility;
- Urgent cases must be seen within 48 hours;

[8] These standards may be modified by BMS, in which case the contract and program requirements will supersede this document.

- Routine cases (as defined in Article II of this contract) other than clinical preventive services (as defined in Article II of this contract), must be seen within 21 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 14 days of the date on which the woman is found to be pregnant; and

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.

Specialty Care

The MCO must provide or arrange for necessary specialty care, including women's health services. 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 primary care physician for routine services, if the primary care provider is not a women's health specialist. The MCO should have a policy encouraging provider consideration of beneficiary input in the provider's proposed treatment plan.

Provider Qualification and Selection

Each MCO shall 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 42 CFR 455.106.
For physicians and other licensed health care professionals, including members 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 suspending or terminating affiliation with a contracting health care professional, including an appeals process, and for reporting serious quality deficiencies to appropriate authorities.

The application process must include a statement by the applicant regarding:

- Any physical or mental health problems that may affect current ability to provide health care;

- Any history of chemical dependency/substance abuse;
- History of loss of license and/or felony convictions;
- History of loss or limitation of privileges or disciplinary activity; and
- An attestation to correctness/completeness of the application.

During the initial credentialing process, the MCO must verify:

- The practitioner holds a current valid license to practice;
- Valid DEA or 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 practitioner as the primary admitting facility (this requirement may be waived for practices which do not have or do not need access to hospitals);
- The practitioner 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/BNDD number;
- Any curtailment or suspension of medical staff privileges (other than for incomplete records);
- Any sanctions imposed by Medicare, Medicaid, or Title XX programs;
- Any censure by the State or County Medical Association;
- Any enrollee complaints

In addition, the MCO must request information on the practitioner from the National Practitioner Data Bank and the State Board of Medical Examiners.

Following initial credentialing and acceptance of a provider into the network, the MCO must conduct exclusion searches of network providers and persons with ownership and control interests in network providers and managing employees using the HHS-OIG's List of Excluded Individuals/Entities or CMS' Medicare Exclusion Database on a monthly basis.

Additional credentialing criteria for PCPs include:

- A visit to the practitioner's office, including documentation of a structured review of the site and medical record keeping practices to ensure conformance with the MCO standards;

- Adherence to the Principles of Ethics of the American Medical Association, the American Osteopathic Association, or any appropriate professional organization;
- Ability to perform or directly supervise the ambulatory primary care services of enrollees; and
- Assurance that any non-physician practitioners are performing within the scope of their licensure.

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.

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.

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 the Department by the 15th of each month with the names and addresses of any health care professional, institutional provider, or supplier that is denied credentialing, suspended, or terminated because of concerns about provider fraud, integrity, or quality deficiencies during the prior calendar month. The report must also state the action taken by the MCO (e.g., denied credentialing). The MCO must also report any health care-related criminal convictions, when disclosed, to the Department. The MCO must also notify appropriate licensing and/or disciplinary bodies and other appropriate authorities. If the MCO does not have any individuals to report from the prior period, the MCO must submit the report stating that it did not have any providers who were denied credentialing, suspended, or terminated for that period.

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 shall 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 shall 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 shall give the affected providers written notice of the reason for its decision.

All contracted providers must meet the credentialing and recredentialing requirements listed in this contract.

Service Area

All enrollees of the MCO must reside in the service area approved by BMS, set forth in Contract Exhibit 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. The MCO must notify BMS 45 days prior to the desired effective date of the service area expansion. BMS will issue its approval or disapproval in 30 days, subject to the timely receipt of all necessary information from the MCO to make the determination. 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 shall notify BMS 90 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 shall 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.

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 promptly of any changes to the composition of its provider network that materially affect the MCO's ability to deliver all capitated services in a timely manner. The MCO must provide BMS and the enrollment broker with advanced written notice of any network deletions that will affect more than 100 members. The MCO shall 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 30 days 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 shall make a good faith effort, as appropriate, to provide written notice to enrollees when a contracted provider has been terminated, within 15 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.

Contract Requirements

The MCO's provider contracts or addenda to provider contracts must abide by all federal regulations, including 42 CFR 455.105 and must be consistent with the requirements of this statement of work and must include the following provisions:

1. Enrollees will be held harmless for the costs of all Medicaid-covered services provided;

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; and
4. Clear definition of each party's termination options.

Contracts with primary care providers (PCPs) must also include a requirement that the provider have 24-hour physician coverage.

The MCO must comply with the prohibitions on inappropriate physician incentives as specified in Article III, Section 2.8 of this contract.

2.2 Primary Care Providers (PCPs)

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:

1. Maintaining continuity of each enrollee's health care by serving as the enrollee's primary care provider;
2. Providing 24-hour, seven-day-a-week access;
3. Making referrals for specialty care and other medically necessary services, both in-plan and out-of-plan, consistent with the MCO's utilization management policies;
4. 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;
5. Adhering to the EPSDT periodicity schedule for enrollees under age twenty-one (21); and
6. 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 can 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.

Number of Members to a PCP

The MCO is expected to ensure that the Medicaid member caseload of any PCP in its network does not exceed 1,500 Medicaid members. The 1,500 Medicaid member 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.

Recognizing that precise numerical ratios are not readily enforceable, the MCO must take measures to ensure compliance with this requirement such as monitoring PCPs' caseloads and enrollees' access to PCPs. BMS will monitor PCP caseloads across MCOs and notify each affected MCO if the total Medicaid member caseload of a PCP in its network exceeds 1,500 Medicaid members. MCOs must reduce the caseload for PCPs with panels above 1,500 Medicaid members across the program unless one of the exceptions above is granted.

Assignment of PCP

The MCO must have written policies and procedures for assigning each of its members 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 10 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 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.

Types of Primary Care Providers

The MCO may designate the following providers as PCPs, as appropriate:

1. Certified nurse midwives;
2. Advanced practice nurses (nurse practitioners); and
3. Physicians with the following specialties:
    - General practice;
    - Family practice;
    - Internal medicine;
    - Obstetrics/gynecology; and
    - Pediatrics.

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.

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.

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 members to select other PCPs or make a reassignment within 15 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 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 attempts within 90 calendar days) to accommodate the enrollee; or
4. The enrollee has taken legal actions against the PCP.

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 population's 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.

---

[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.

2.4 Publicly Supported Providers

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 30-minute travel time standards for routinely-used delivery sites as specified in this contract. 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 members 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, that are at least equal to those offered to other providers of comparable services. The MCO cannot 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, with proper documentation from CMS, the MCOs shall update payment rates to FQHC/RHC effective the date of notification. 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 30 days of notification of the payment rate change. BMS will reconcile reasonable costs with FQHCs and RHCs.

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.

---

[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.

The MCO must provide the following core services to Medicaid managed care members 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.
4. Childhood immunizations. The MCO must obtain vaccines from the State Bureau for Public Health's Immunization Program. Any time an MCO member seeks immunizations from a governmental public health entity, the MCO shall pay for such services at current Medicaid fee-for-service 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 should encourage providers to refer their patients to these programs.

Environmental lead assessments for MCO children with elevated blood levels will be reimbursed directly by BMS.

The MCO must work with the local health departments to coordinate the provision of the above services and to avoid duplication of services.

The MCO is encouraged, but not required, to contract with local health departments to provide the core services listed above as well as other services.

Critical Access Hospitals

The MCO is encouraged, but not required, to contract with Critical Access Hospitals (CAH) for inpatient and outpatient hospital services. Upon BMS notification to the MCO of any changes to the CAH reimbursement rates, the MCOs shall update payment rates to CAHs effective the date of notification. 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 30 days of notification of the payment rate change.

Primary Care Centers

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

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.

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.

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 members 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.

Children with Special Health Care Needs Program (CSHCN) Providers

The Children with Special Health Care Needs (CSHCN) Program provides specialty medical care, diagnosis and treatment for disabled children and those who may be at risk of developing disabling conditions. The CSHCN program provides case management and access to specialty services through a system of outreach specialty clinics.

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.

2.5 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 1,500 Medicaid enrollees, the PCP may admit additional, non-Medicaid patients.

2.6 Provider Services

Provider Services Department

The MCO must staff a Provider Services Department, to be operated at least during regular business hours and to be responsible for the following:

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 in regards to Mountain Health Choices (e.g., explaining the West Virginia Medicaid Member Agreement and the Health Improvement Plan, explaining how to help a beneficiary enroll in the enhanced benefit package, and explaining the benefits provided under both the basic and the enhanced benefit packages); 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.

Provider Manual

The MCO shall develop, distribute and maintain a provider manual. The MCO shall document the approval of the provider manual by the MCO Administrator and Medical Director and shall maintain documentation that verifies that the provider manual is reviewed at least annually. The MCO shall ensure that each provider (individual or group which submits claim and encounter data) is issued a copy of the provider manual.

2.7 Provider Reimbursement

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, regardless of the specific arrangements it 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 fee-for-service 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.

In-Network Services

The MCO must make timely payment within 30 calendar days for medically necessary, covered services rendered by in-network providers 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, or
3. Services were prior authorized.

Out-of-Network Services

The MCO must make timely payments to out-of-network providers in accordance with 42 CFR 447.45 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, or
3. Services were prior authorized.

The MCO is responsible for negotiating reimbursement with the non-network provider.

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 shall 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 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.
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 primary care physician or other plan representative instructs the beneficiary to seek emergency care in-network or out-of-network, the plan 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 shall 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.

Critical Access Hospitals

MCOs contracting with Critical Access Hospitals (CAH) shall make payment to CAH at the prevailing Medicaid reimbursement rate. MCO contracts with CAH shall stipulate this reimbursement arrangement. Upon BMS notification to the MCO of any changes to the CAH reimbursement rates, the MCOs shall update payment rates to CAH effective from the designated CMS 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.

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 recipient 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 will not be held to this requirement should BMS be delayed in its payment to the MCO by a period of more than 15 days. In such a situation, the MCO may delay payment to contracted and non-contracted providers by a period not to exceed the delay in payment from BMS. The MCO must provide payment to affiliated health care providers for items and services covered under this contract on a timely basis, consistent with the claims payment procedures described in section 1902(a)(37)(A) of the Social Security Act and the implementing Federal regulation at 42 CFR 447.45, outlined above, unless the health care provider and organization agree to an alternative payment schedule. The MCO must make timely payments to out-of-network providers for medically necessary, covered services.

The MCO must pay at least 90 percent of all clean claims (claims that pass all edits required for payments by the MCO) from subcontractors for covered services within 30 calendar days of receipt and pay at least 99 percent of all clean claims within 90 calendar days of receipt, except to the extent subcontractors have agreed to later payment. The MCO must pay all other claims, except those from providers under investigation for fraud and abuse, within 12 months of the date of receipt. The MCO must agree to specify the date of receipt as the date the agency receives the claim, as indicated by its date stamp on the claim, and date of payment as the date of the check or other form of payment.

Payments for Provider-Preventable Conditions

Section 2702(a) of the Affordable Care Act 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 BMS policy. Additionally, the MCO must comply with any reporting requirements mandated by CMS to document the occurrences of PPCs in the Medicaid program.

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 shall not make specific payment, directly or indirectly, to a physician or physician group as an inducement to reduce or limit medically necessary 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 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 10 working 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, withholds, bonus, capitation.
- The percent of any withhold or 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 shall comply with any additional rules regarding physician incentives released by CMS.

3. ENROLLMENT & MEMBER SERVICES

The program will enroll the TANF and TANF-related populations. Enrollment in the Mountain Health Trust Program will be handled by BMS through a contract with the central enrollment broker. The enrollment broker is responsible for conducting outreach and enrolling eligible Medicaid beneficiaries into the Mountain Health Trust Program. The enrollment broker is also responsible for enrolling members into Mountain Health Choices. 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 shall 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.

3.1 Marketing

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.

Marketing Plan

The MCO must submit a marketing plan to the Department for prior written approval by October 1 of each contract year. If the marketing plan is modified during the contract year, the revised marketing plan must be submitted to the Department for written approval prior to engaging in any activities not specified in the original plan.

Marketing Materials

The MCO must develop marketing materials for the enrollment broker to assist Medicaid enrollees with their MCO selection. The MCO must include a Medicaid member 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, recipients receive accurate oral and written information needed to make an informed decision on whether to enroll. Materials should use an easily readable typeface (such as 12 or 14 point), frequent headings, and should provide short, simple explanations of key concepts. Technical or legal language should be avoided whenever possible. The MCO must submit evidence to BMS that its materials satisfy this requirement[11] and provide a written assurance that marketing materials do not mislead, confuse or defraud recipients or BMS. Such written assurance shall be

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

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.

Any changes to marketing materials must be submitted to BMS for approval.

Marketing Guidelines

Enrollment will be handled by BMS through a contract with a central enrollment broker. The MCO must submit to BMS for prior written approval a marketing plan and all marketing materials prepared pursuant to said plan. General health education brochures and materials do not require approval from BMS. BMS will review the marketing plan and all marketing materials as soon as possible but within 45 days to ensure that materials are accurate and do not mislead, confuse or defraud beneficiaries or BMS in accordance with 42 CFR 438.104. The MCO agrees to engage only in marketing activities that are pre-approved in writing, except those marketing materials that are deemed approved if there is no response from BMS within 45 days of date of receipt. However, problems and errors subsequently identified by BMS must be corrected by the MCO as they are identified.

The MCO must follow the marketing guidelines described in Exhibit D, BMS Marketing Guidelines. These include, but are not limited to, the following policies and requirements regarding solicitation of new enrollees:

1. The MCO may not distribute, directly or through any agent or independent contractor, marketing materials within BMS:
   - without prior approval of BMS, and
   - that contain false or misleading information.
2. The MCO must distribute marketing materials to the entire service area of the MCO's contract.
3. The MCO, or any agency of such MCO, may not seek to influence an individual's enrollment with the MCO in conjunction with the sale of any other private insurance.
4. The MCO cannot, either directly or indirectly, conduct door-to-door, telephonic or "cold-call" marketing of enrollment. Cold call marketing is defined in Article II Section I.

3.2 Enrollment

Process

The MCO shall conduct continuous open enrollment during which the MCO shall accept recipients eligible for coverage under this contract in the order in which they are enrolled without regard to health status of the recipient 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 the Department or the enrollment broker) up to the limits set by the Department. The MCO shall not attempt to discourage or delay enrollment of eligible Medicaid recipients.

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 members may have pre-existing, chronic, or catastrophic illnesses, conducting outreach, and developing appropriate treatment plans for these members.

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

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 patient is transferred during the stay) will be the responsibility of BMS until discharge. The MCO is responsible for all other covered services provided on or after the effective date of enrollment. The MCO is financially responsible for all covered services upon discharge from the inpatient facility (e.g., home health services, physical therapy, physician follow up). The only exception is for a newborn born to a mother who is an enrollee. If the MCO discovers an enrollee's initial enrollment is effective in the middle of an enrollee's confinement to an inpatient care facility, it must notify BMS.

For MCO enrollees receiving inpatient care at the time of disenrollment, coverage of services at the inpatient care facility provided after the effective date of disenrollment will be the responsibility of the MCO until the member is discharged. Coverage of outpatient services will be the responsibility of BMS as of the effective date of disenrollment.

Automatic Reassignment Following Resumption of Eligibility

Medicaid beneficiaries who lose eligibility for the West Virginia Mountain Health Trust program and regain eligibility within 60 days 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 60 days, the beneficiary will be permitted to select a plan through the standard enrollment broker process.) Medicaid beneficiaries will also be automatically re-enrolled in their previous Mountain Health Choices benefits package if they lose and regain eligibility within 60 days.

Enrollment of Program Newborns

The MCO must have written policies and procedures for enrolling newborn children of Medicaid members 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 30 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 services provided under the standard benefit package to the newborn child or an enrolled mother for the first 60 to 90 days of life based upon the cut-off date for MCO enrollment with the enrollment broker. The child's date of birth shall be counted as day one. BMS will pay a full month's capitation for all newborns. The MCO shall 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 60 days of the date of delivery or as soon thereafter as the MCO becomes aware of the delivery.

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.

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 a recipient 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 10 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.

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 30 days before the termination date and promptly assist enrollees in obtaining a new primary care provider.

Enrollment Limits

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 45 days prior to the desired effective date of the change. BMS will issue its approval or disapproval in 30 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.

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 or the PAAS program. Disenrollment may be initiated by the enrollee, MCO, or BMS.
The MCO must inform recipients 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.

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. Failure of BMS to make a premium payment on behalf of a member.
3. 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 immediately reenroll into a new MCO.
4. Continuous placement in a nursing facility, State institution or intermediate care facility for the mentally retarded for more than 30 calendar days.
5. 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.
6. Beneficiary death.

The MCO may not initiate disenrollment for any member 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 recipient 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. 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 shall 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 a member, the MCO shall 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 shall be considered approved.

Enrollee-Initiated Disenrollment

MCO enrollees may request disenrollment at any time for any reason. Disenrollment shall 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.

3.3 Member Services Department

General Requirements

The MCO must establish a Member Services Department that must be accessible during normal business hours and through a toll-free phone number. The Member Services Department must work with both Medicaid enrollees and providers to handle questions and complaints and to facilitate the provision of services.

3.4 Materials

Enrollee Information

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 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.

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.

Member ID Cards

The MCO must issue an identification card for its Medicaid members to use when obtaining MCO services. The card should 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 45 calendar days of enrollment. The MCO may only issue one identification card for all covered benefits. PCP information must be updated when available. The card must include at least the following information:

1. Beneficiary name;
2. Beneficiary Medicaid identification number;
3. MCO name;
4. 24-hour telephone number for use in urgent or emergent medical situations;
5. Telephone number for member services (if different);
6. Primary care provider name and office telephone number; and
7. Notice that the member must present both the MCO card and the Medicaid card at time of service.

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 a member's eligibility and enrollment.

Member Handbook

The MCO shall mail an enrollee handbook to the enrollee's household within one week of official enrollment notification to the MCO. The MCO must provide periodic updates to the enrollee handbook as needed explaining changes in the above policies. When there are program or service site changes, notification will be provided to the affected enrollees at least fourteen calendar days before implementation. The MCO shall maintain documentation verifying that the member handbook is reviewed at least once a year. The MCO shall provide a member handbook to potential enrollees upon request.

The MCO must submit the member handbook to BMS for approval prior to distribution to enrollees or other Medicaid beneficiaries. Copies of the handbook must be sent to the enrollment broker and BMS. The MCO must make modifications in handbook language if directed to do so to comply with the requirements as described above. BMS will give written notification of approval/disapproval of the member handbook to the MCO within 30 calendar days. Changes to the member handbook must also be submitted to BMS for approval prior to distribution.

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

1. Table of contents;
2. The phone number which can be used for assistance in obtaining emergency care;
3. A description of all available 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. The phone number for the member services department, hours of operation, and a description of its function;
5. Informal and formal grievance, appeal, and state fair hearing procedures, including:
    - Filing procedures, requirements, and timeframes for complaints, grievances and appeals, and state fair hearing;
    - The method of obtaining a hearing and the rules governing representation at a hearing;
    - The availability of assistance if filing grievances and appeals, the toll-free numbers available for filing a grievance or appeal by phone;
    - 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
    - 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;
6. Disenrollment policies;
7. How to obtain early and periodic screening, diagnosis and treatment (EPSDT) services;
8. Information on family planning services, including a discussion of members' right to self-refer to in-plan and out-of-plan, Medicaid-participating family planning providers;
9. Information on Mountain Health Choices, including a process that explains to the member how to obtain the additional services provided through the Enhanced benefit program;
10. Information concerning policies on advance directives;
11. 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;
12. The fact that prior authorization is not required for emergency services;
13. The enrollee's right to use any hospital or other setting for emergency care;
14. Procedures for obtaining services covered under the Medicaid state plan and not covered by the MCO (e.g., pharmacy, behavioral health);
15. The extent to which and how to access post-stabilization services;
16. Limited MCO liability for services from non-MCO providers, e.g., only emergency care or referrals;
17. The phone number of the enrollment broker;
18. Information about choosing and changing PCPs;

19. Information about what to do when family composition changes;
20. Appointment procedures and access standards including travel time, scheduling standards and the MCO's standard waiting time;
21. Guidance to seeking care when out-of-area services are required, including authorization requirements and process;
22. How to obtain emergency transportation, medically necessary transportation and non-emergency transportation;[12]
23. How to obtain maternity and sexually transmitted diseases services;
24. How to obtain behavioral health services and pharmaceuticals under the current fee-for-system;
25. Information on enrollees' rights to access certified nurse midwife services and certified pediatric or family nurse practitioner services;
26. Procedures for recommending changes in policies or services;
27. What to do in the case of out-of-county and out-of-state moves;[13]
28. What to do if the member has a worker's compensation claim, pending personal injury or medical malpractice law suit, or has been involved in an auto accident;
29. 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;
30. Information on enrollee rights and responsibilities, as outlined in this contract;
31. Any significant changes, as defined by BMS, to the information above, at least 30 days before the effective date of the change and no later than the actual effective date;
32. The MCO's policies regarding the appropriate treatment of minors; and
33. The MCO shall advise enrollees at least annually of their right to request and obtain the above information.

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.

---

[12] The MCO should contact the county BMS office to obtain information on how enrollees can obtain non-emergency transportation and medically necessary transportation.

[13] The MCO should contact the county BMS office to obtain information on what enrollees need to do in the case of out-of-county and out-of-state moves.

Provider Directory

The provider directory must include a list of the names, telephone numbers, and service site addresses of PCPs, specialists, and hospitals. The information given to enrollees regarding providers must include information on non-English languages spoken by current providers in the enrollee's service area, and any restrictions on enrollees' ability to select from among network providers. The directory must clearly indicate which PCPs are not accepting new patients, and provide an explanation to the effect that members can select a PCP with a closed panel if that PCP was their primary fee-for-service provider. The provider directory must also specify which providers are handicap accessible. The directory must include information regarding ancillary care providers on which enrollees with special health care needs may be dependent for care, or an explanation of how enrollees can obtain this supplemental information.

The MCO must update the provider directory at least every 90 days. 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 shall provide potential enrollees a copy of the provider directory, upon request.

3.5 Education

New Member 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 fee-for-service system;
6. How to register a complaint or file a grievance;
7. Members' rights and responsibilities; and
8. Contents of the Medicaid member handbook.

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 Mountain Health Choices, the MCO must provide weight management and tobacco cessation benefits for adults and children enrolled in the enhanced plan and tobacco cessation benefits children enrolled in the enhanced plan and children enrolled in the basic plan. These benefits are in addition to any health education and preventive care programs.

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, drug abuse, alcohol abuse, 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 benefits including physical examinations that are available and designed to prevent illness. The MCO shall keep a record of all activities it has conducted to satisfy this requirement.

Health Screenings

The MCO may offer health screenings at community events, health awareness events, and in wellness vans to its enrollees and other members of the community. The MCO shall instruct each enrollee that receives a screen to contact his or her PCP if medical follow-up is necessary and shall ensure that each enrollee receives a printed summary of the assessment information to take to his or her PCP. The MCO shall also transmit a summary of the assessment information directly to each enrollee's PCP.

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 should be included in the member handbook;
2. Ensuring that written information reflects changes in State law as soon as possible, but no later than 90 days after the effective date of the change;
3. Documenting in the member's medical record whether or not the member has executed an advance directive;
4. Not conditioning the provision of care or otherwise discriminating against a member based on whether the member 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 the Department survey and certification office.

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

3.6 Enrollee Rights

Written Policies on Enrollee Rights

The MCO must have written policies with respect to the enrollee rights specified below. The MCO must articulate enrollees' rights, promote the exercise of those rights, and ensure that its staff and affiliated providers 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 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.

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 30 days from receipt of a request for records, and no later than 60 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.

MCOs must have policies and procedures to protect and promote these rights, as follows:

- **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.

- **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.

- **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.B.

  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.

- **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:

  1. The enrollee's health status, medical care or treatment options, including any alternative treatment that may be self-administered;
  2. Any information the enrollee needs for deciding among all relevant treatment options; or
  3. The risks, benefits and consequences of treatment or nontreatment.

- **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:

  1. 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 should be included in the member handbook);

2. Documenting in the enrollee's medical record whether or not the enrollee has executed an advanced directive;
3. Not conditioning the provision of care or otherwise discriminating against a enrollee based on whether the enrollee has executed an advance directive;
4. Ensuring compliance with requirements of state law respecting advance directives; and
5. 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, member satisfaction surveys, and other sources of member input.

Communication Barriers

The MCO will be required to provide oral interpretive services for languages on an as-needed basis. These requirements will 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 shall be provided free of charge to enrollees and potential enrollees and shall 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 5 percent of the Medicaid population). Within 90 days of notification from BMS, the MCO shall 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 shall 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 shall also notify enrollees and potential enrollees of how to access such services.

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 handbooks, in alternative formats (i.e., large print, Braille, cassette and diskette for participants with sensory impairments).

Cultural Competency

The MCO shall 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.

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.

3.8 Grievances and Appeals

The MCO's grievance 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 the Department (42 CFR 434.32).

Resolution of Enrollee Issues

Medicaid enrollees may file a grievance regarding any aspect of service delivery provided or paid for by the MCO. The MCO shall submit to the Department 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 (informal and formal steps) 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 shall 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 nonrenewals 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 shall be included in the member handbook provided to enrollees. This procedure shall be administered at no cost to the enrollee.

c. As part of MCO's enrollee grievance and appeal procedure, the MCO shall:

i. Make available both informal and formal 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 and toll-free phone numbers as specified by the MCO;

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 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 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;

ix. Process and provide notice to affected parties regarding the enrollee grievance in a reasonable length of time not to exceed 45 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;

x. Ensure that standard resolution and notice occurs with the timeframes established by BMS and that such timeframes may be extended up to 14 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

xi. Ensure that if the timeframe for resolving a grievance is extended for any reason other than an enrollee request, the MCO shall give the enrollee written notice of the reason for the delay.

2. In addition to the provisions stated above in Subsection (c), the MCO's procedures with respect to appeals and formal grievances shall provide that:

a. An address shall 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 shall be taken against a provider who files an appeal on behalf of an enrollee or supports the enrollee's appeal;

d. If an expedited appeal or review of a formal grievance is not requested, written and signed appeals and formal grievances must be filed following an oral appeal or formal grievance;

e. 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, including medical records, before and during the appeal or formal grievance as well as other documents

considered during the appeal. Parties to the appeal shall include the enrollee, his representative, or legal representative of a deceased enrollee's estate;

f. The time limit for the enrollee to file an appeal or formal grievance is 90 days from the date on the notice of action;

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

h. Each MCO shall maintain an accurate record of each appeal and formal grievance;

i. Copies of the grievances and the responses thereto shall be available to the public for inspection for three years;

j. The MCO shall process and provide notice to affected parties regarding the appeal or formal grievance in a reasonable length of time not to exceed 45 days from the day the MCO receives the appeal or formal 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 14 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 shall give the enrollee written notice of the reason for the delay; and

m. MCOs must provide written notice of the disposition of appeals which shall 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 services, which could seriously jeopardize the enrollee's health and well-being. This includes a grievance regarding any service related to a member's formal treatment plan as developed by the MCO and PCP. The MCO must report these grievances to BMS immediately, and BMS will then determine the timeline for resolving the grievance. The expedited process for appeals and formal grievances shall meet the requirements of Subsections 1 and 2 above and also shall 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 of appeals 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 in 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 calendar days;

   c. The MCO shall 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 3 working days after the MCO receives the appeal, or the timeframe specified in the West Virginia HMO Act of 1977. The 3 working day timeframe may be extended by up to 14 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 shall 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 shall 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 shall implement any decision made by the Department pursuant to such a review. Enrollees must exhaust all MCO grievance and appeals procedures prior to requesting a state fair hearing.

5. Notice of Action

The notice of action must be in writing and must meet the readability requirements of Article III, Section 3.4 of this contract.

a. The notice must include the following information:

i. The action taken or intended to be taken by the MCO;

ii. The reasons for the action;

iii. The right of the enrollee or his provider to appeal the action to the MCO;

iv. The enrollee's right to request a state fair hearing;

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 action must be mailed:

i. For termination, suspension or reduction of previously authorized Medicaid-covered services, at least 10 days before the date of the action;

ii. No later than the date of action 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 30 days (applies only to adverse actions for NF transfers); or
- the date of action will occur in less than 10 days in accordance with 42 CFR 438.12.

iii. For actions due to probable fraud by the enrollee, no later than 5 days in advance of the action;

iv. For denial of payment, at the time of any action affecting the claim;

v. Within 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 3 working days after the receipt of a request for an expedited authorization.

c. Information for Providers

The MCO shall provide all providers and subcontractors upon entering into a contract with the Plan, the same information pertaining 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 shall be the responsibility of the State. The MCO is responsible for cooperating with the State in the fair hearings process and is considered a party to state fair hearings. 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. The MCO shall also provide enrollees with information about the right to request a state fair hearing as set forth in this contract.

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 ten days of the MCO mailing of the notice of action or the intended effective date of the MCO's proposed action);
   - The enrollee or provider is appealing a decision to terminate, suspend, or reduce a previously authorized course of treatment;
   - 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 shall be continued or reinstated until:

   - The enrollee withdraws the appeal;
   - Ten days after the MCO mails the notice of resolution of the appeal against the enrollee, unless the enrollee within the 10-day timeframe, has requested a state fair hearing with continuation of benefits until a state fair hearing decision is reached; or
   - The time period or service limits of a previously authorized service have been met.

   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 shall authorize or provide the disputed services promptly or as expeditiously as the enrollee's health condition requires. 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.

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 business days and financial decisions pertaining to claims payment issues within five 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 formal and informal 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;
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

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

The MCO must cover services covered under the contract out-of-network for the enrollee if the network is unable to provide such services and shall 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 in an adequate and timely manner, as defined by BMS, and for as long as the MCO is unable to provide them. To the extent possible, the MCO shall encourage out-of-network providers to coordinate with the MCO with respect to payment.

5.3 Continuity and Coordination of Care

The MCO must ensure continuity and coordination of care through use of an individual or entity who is formally designated as having primary responsibility for coordinating the enrollee's overall health care services. The MCO must have a procedure to coordinate the services that the MCO provides to the enrollee with services provided by other MCOs and to promote case management. The MCO must also have procedures for timely communication of clinical information among providers. The MCO must share the results of the assessment for enrollees with special health care needs with other MCOs serving the enrollee. 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 generally available through contracting or non-contracting providers in the area served by the MCO. The MCO should 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.

5.4 Service Authorization

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. 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 and approve the provision of medical services. The plan must have mechanisms to detect both underutilization and overutilization of services. 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. The MCO shall 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, as determined by BMS. The MCO shall 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 should 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.

The MCO must make authorization decisions and provide notice as expeditiously as required by the enrollee's health condition and within 14 calendar days of receiving the request for service for the purposes of standard authorization decisions. This 14 calendar day period may be extended up to 14 additional days upon request of the enrollee or provider, or if the MCO justifies to BMS the need for additional information and how the enrollee might benefit from the extension.

The MCO must provide an expedited authorization for services when the provider indicates that the standard time frame 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, and no later than 3 working days after receipt of the request for service. This 3 working day period may be extended up to 14 additional days upon request of the enrollee or provider, or if the MCO justifies to BMS the need for additional information and how the enrollee might benefit from the extension.

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 services.

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 shall permit enrollees to choose from at least two physicians, and to obtain services from an out-of-network provider under any of the following circumstances:

- The 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 recipient needs related services that would subject the recipient to unnecessary risk if 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 60 days of enrollment. The provider 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 60 days of enrollment, after being given an opportunity to select a participating provider.

5.6 Coordination of Care

Internal 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 members 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; and
5. Coordination and provision of EPSDT services as defined in Article III, Section 1.2.A.

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 coordination of care manager for his/her patients' overall care.

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 include assessing enrollees' conditions, identifying medical procedures to address and/or monitor the conditions, developing treatment plans appropriate for those enrollees determined to need a course of treatment or regular care monitoring, coordinating hospital admission/discharge planning and post-discharge care and continued services (e.g., rehabilitation), providing assistance to enrollees in obtaining behavioral health and community services, and providing assistance in the coordination of behavioral health, physical health and all other services.

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 must specify the criteria used in denying or limiting authorization and include information on how to request reconsideration of the decision pursuant to the procedures. The notice to the enrollee must be in writing.

External Coordination of Care

Family Planning

Family planning services will be tracked, coordinated and monitored by the MCO. The MCO will assume financial risk for these services. Through its reimbursement of other providers, the MCO will be able to monitor members' utilization of such services. Additionally, the MCO will ask out-of-network providers to encourage members to permit the release of necessary medical data to the MCO.

The MCO shall ensure that enrollees who seek family planning services from the plan shall be 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 shall make appropriate referrals as necessary. All family planning services will be included in the encounter data that all health plans must report to BMS.

Behavioral Health

The MCO must coordinate behavioral health services with the fee-for-service behavioral health providers. Actions by the MCO which indicate a deliberate intent to avoid financial responsibility for services that are the duty of the MCO to provide will be subject to sanctions.

Fee-For-Service Health Care

The MCO must follow established Medicaid procedures and provide referrals and assistance in scheduling appointments to enrollees in need of Medicaid covered services outside of the scope of this contract as defined in Contract Exhibit 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.

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 6 months postpartum), infants, and children under the age of 5 to WIC. The MCO must include timely (not more than 60 days) referral of medical information (length/height, weight, hemoglobin and medical condition which influences consumption, adsorption, or utilization of food nutrients).

School-Health Related Services.

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

Community and Social Services

The MCO must have programs for coordination of care that include coordination of services with community and social services generally available through contracting or non-contracting providers in the area served by the MCO.

Coordination of Care for Persons with Special Health Care Needs

The MCO must have procedures for identifying individuals with complex or serious medical conditions. The MCO shall 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. Treatment plans shall specify an adequate number of direct access visits to specialists to accommodate implementation of the treatment plan. The treatment plan must be developed by the enrollee's primary care provider with participation from the enrollee, 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; shall be approved by the MCO in a timely manner if such approval is required; and shall meet applicable quality assurance and utilization standards. These treatment plans must be time-specific and updated periodically by the primary care provider.

The MCO must share the results of the state identification and MCO assessment of enrollees with special health care needs with other MCOs serving enrollees. The MCO shall 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 member and PCP to facilitate specialty referrals, coordinate hospital admission/discharge planning, post-discharge care and continued services (e.g., rehabilitation), and coordinate with services provided on a fee-for-service basis.

5.7 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 shall 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 Mountain Health Trust 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.

5.8 Practice Guidelines and New Technology

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 should 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 guidelines.

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

5.9 Enrollee Medical Records and Communication of Clinical Information

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. 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 90 days of the effective date of enrollment. The MCO must ensure that each provider furnishing services to enrollees maintains an enrollee health record. PCPs must establish and maintain a confidential, centralized medical record for each enrollee that details care received. The medical record should demonstrate coordination of patient care; for example, relevant medical information from referral sources must be reviewed and entered into enrollees' medical records. Medical records shall be maintained in accordance with standards established by the MCO that takes into account professional standards.

These standards 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:

- 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 martial status;
- Entry date;
- 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 3 or more times): serious accidents, operations, illnesses, prenatal care and birth (for pediatric patients);
- Immunizations: for pediatric records (ages 12 and under) there is 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 abuse: notation concerning cigarette and alcohol use and substance abuse is present (for patients 14 years and over and seen three 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, including encounter forms with notations concerning follow-up care, or visits; return times noted in weeks, months or PRN; 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.
- Information needed to conduct utilization review as specified in 42 CFR 456.111 and 42 CFR 438.211.

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

The MCO should have policies and procedures for promptly sharing enrollee information with any organization with which the enrollee may subsequently enroll.

5.10 Confidentiality

The MCO must have written policies and procedures for maintaining the confidentiality of data, including medical records/enrollee information and adolescent/STD appointment records. The MCO's policies shall be in accordance with the privacy requirements in 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 shall 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. 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.

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 shall be confidential and shall not be released without the written consent of the covered persons or responsible party, except as specified below.
    i) 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.
    ii) 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.

iii) 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 shall 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.

5.11 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 Department reporting requirements. Such requirements encompass the content of the reports, the format in which they must be transmitted, and the timeframes for submission. Exhibit E summarizes reporting requirements and timeframes.
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 shall submit the certification concurrently with the certified data. The format for the data certification is included as Exhibit F.

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 45 days following the end of the quarter.

Grievance and Appeals Reporting

The MCO must provide BMS with quarterly reports documenting the number and types of formal grievances and appeals registered by enrollees and providers, and the status or disposition of grievances and appeals. Reports must be submitted no later than 45 calendar days after close of the quarter to which they apply. At a minimum they must include:

- Total grievances (informal and formal) and appeals by nature of complaint under the following categories:
    - Service denied (e.g., non-covered, not medically necessary, out-of-area non-participating provider, no referral, referral denied, other);
    - Payment (e.g., disputed amount, timeliness, other);
    - Service complaints (e.g., inability to access a member service representative and/or medical management staff by phone, members' handbooks and evidence of coverages not sent to the recipient within a reasonable period of time, misleading or outdated information noted in the MCO's provider directory, other); and
    - Quality of care.

- Total number of grievances (informal and formal) and appeals resolved in favor of the enrollee, against the enrollee, withdrawn, referred to formal process (if applicable), and the number remaining open.
- Total number of informal and formal grievances.
- Average, median, longest, and shortest turnaround time for informal and formal grievances.

Member Satisfaction Reporting

The MCO must survey a sample of its adult and child members at least annually to determine satisfaction with the quality of MCO care and services including: physician accessibility, ancillary services and appointment wait time. The MCO must use the Consumer Assessment of Health Plans (CAHPS) survey to be approved by BMS. Survey results must be reported to BMS annually, on or before June 15. The MCO shall 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.

Encounter Reporting

The MCO is responsible for submitting encounter data for all services rendered that fall within the defined benefit package. Encounter data must be submitted monthly and no later than 30 calendar days after the end of the period in which the encounters occurred. All encounters 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 shall 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 should 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 Department of Health and Human Services.

HEDIS Reporting

The MCO must report unaudited HEDIS measures to BMS annually by June 15. While a HEDIS audit is not required, if the MCO chooses to perform a HEDIS audit, the audited results should be submitted to BMS upon receipt from NCQA. BMS will provide guidance to MCOs regarding which measures should be reported, according to the current version of HEDIS.

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 below. 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 1, the MCO must submit audited financial statements.

2. *Department of Insurance Reports:* The MCO must submit copies of its quarterly and annual Department of Insurance reports, as well as any revisions thereto. The MCO must include reports on the solvency of its intermediaries. These reports are due on the same due dates for reporting to the Department of Insurance. Any revisions to a quarterly and/or annual Department of Insurance report must be submitted on the same day on which the report is submitted to the Department of Insurance.

3. *Medicaid-Related Financial Reports*: The MCO must submit Medicaid-specific financial statements on a quarterly basis.

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 the Department of Health and Human Resources. The three 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 shall submit yearly statements to BMS, by October 1, 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.

Federal Reporting Requirements

The MCO shall comply with the following Federal reporting and compliance requirements for the services listed below, and shall submit applicable reports to BMS. (See Medicaid Physician Provider Manual for state requirements and procedures):

- Abortions shall comply with the requirements of 42 CFR 441. Subpart E – Abortions. This includes completion of the information form, Certification Regarding Abortion.
- Hysterectomies and sterilizations shall comply with 42 CFR 441. Subpart F – Sterilizations. This includes completion of the consent form.
- EPSDT services and reporting shall comply with 42 CFR 441 Subpart B – Early and Periodic Screening, Diagnosis, and Treatment.

MCOs shall submit yearly statements to BMS each year by October 1 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.

Annual Report

The MCO shall submit its annual report to BMS and make copies of the annual report available at the local Department of Health and Human Resources offices in the counties in which it operates. The MCO must also make copies of the annual report available to its members upon request.

Data Necessary for Drug Rebate Collection

Each MCO shall submit to BMS the drug utilization data necessary for the collection of drug rebates in formats to be specified by BMS; no later than 15 days following the end of each month.

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 and frequency will be specified by BMS.

Other Reporting Requirements

Each MCO shall submit to BMS Medicare and private accreditation review reports, findings, and other results from the previous three 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.

6. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT 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 shall 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 enrollee satisfaction. Such improvements must be sustained over time. QAPI strategies should 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;
- 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 as required by BMS. 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

Each MCO must meet certain required levels of performance when providing health care and related services to Medicaid managed care enrollees. Each MCO must meet any goals for performance improvement on specific measures that may be established by BMS. These minimum performance levels will be established by examining historical performance levels as well as benchmarks (best practices) of other health plans and delivery systems. Performance levels for each quality review period will be provided to the MCOs by BMS.

6.2 Performance Improvement Projects

Each MCO must develop and maintain written descriptions of its performance improvement program, including the identification of individual(s) responsible for the program. Each MCO

must conduct performance improvement projects 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. Performance improvement projects 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; identifying and implementing appropriate system interventions to improve performance; and repeating data collections to assess the continuing effect of interventions.

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.

Projects

Each MCO must initiate[14] and maintain performance improvement projects that address the focus areas specified above. The MCO must maintain at least two projects at a time.[15] The performance improvement projects may be selected by BMS. In cases where BMS does not specify a project focus, each MCOmay 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 should 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 should measure changes in health status, functional status, enrollee satisfaction, or valid proxies of these outcomes. Each 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, measure changes in performance, and continue measurement for at least one year after a desired level of performance is achieved. The MCO shall 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. Each plan 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.

---

[14] 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).

[15] CMS requires an MCO contracting with Medicare to perform a third performance improvement project in a focus area chosen by CMS.

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 15 in order to facilitate the use of resulting data in producing annual information on quality of care.

6.3 Systemic Problems

Each 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 should 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
- Procedures for terminating the affiliation with the physician, or other health professional or provider.

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 shall be used in recredentialing, recontracting, and/or annual performance evaluation. QAPI activities shall be coordinated with other performance monitoring activities, including utilization management, risk management, and resolution and monitoring of enrollee complaints and grievances. QAPI activities shall 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 member services.

6.4 Health Information System

Each MCO must maintain a health information system that collects, integrates, analyzes, and reports data 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 health information system must also

provide information including, but not limited to, utilization, 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.

6.5 Administration of the QAPI Program

Each MCO's QAPI program must be administered through clear and appropriate administrative arrangements. The MCO must ensure that sufficient resources and staff with necessary education, experience, or training are available to implement the QAPI.

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.

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 shall meet at least quarterly to oversee QAPI activities and review of the process followed in the provision of health services. Providers shall be kept informed about the written QAPI program. Contemporaneous records shall document the committee's activities, findings, recommendations, and actions. The QAPI committee shall report to the QAPI Policy committee on a scheduled basis on activities, findings, recommendations, and actions. Membership on the QAPI committee shall 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.

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

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 member services), especially with respect to:

- Resolving enrollee issues;
- Authorizing service;
- Developing practice guidelines;
- Recredentialing practitioners; and
- Providing feedback to providers and plan staff regarding performance and enrollee satisfaction surveys.

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 should 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 should 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.

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:

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 60 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

The MCO will be "at risk" for the services listed in Contract Exhibit A (Description of Covered and Excluded Services) through a capitation payment system. The MCO will be paid a fixed rate per member per month (PMPM) and will not be permitted to collect any additional copayments or premiums from enrollees. Contract Exhibit B contains a listing of 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 60 days written notice. BMS must then remedy the conditions contained in the notice within 30 days following the notice of termination or the MCO may terminate 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 termination date of a member's enrollment 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 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 30 days:** If a member has been in a nursing facility or state institution for 30 consecutive 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).

7.3 Third Party Liability

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 should utilize 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. 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 TPL case that is known to the MCO, the MCO must notify BMS within 30 days of the date of its decision 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 shall contact BMS if it becomes aware that an enrollee has become eligible for Medicare while on Medicaid. It shall 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.

7.4 Special Payment Arrangements

Responsibility for Inpatient Care

Coverage of services at an inpatient care facility is considered to be the responsibility of the entity that the enrollee was enrolled under at the time of the initial admission (e.g., MCO, BMS). Responsibility for inpatient care will be assigned accordingly in the following circumstances:

- **Disenrollment:** For MCO enrollees receiving inpatient care at the time of disenrollment, coverage of services at the inpatient care facility provided after the effective date of disenrollment will be the responsibility of the MCO until the member is discharged. Coverage of outpatient services will be the responsibility of BMS as of the effective date of disenrollment. In the case of insolvency, the MCO shall 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 MCO enrollees receiving inpatient care at the time of transfer to another MCO, coverage of services at the inpatient care facility provided after the effective date of disenrollment will be the responsibility of the MCO in which the member was enrolled at the time of the admission, until the patient is discharged from the facility. Coverage of outpatient services will be the responsibility of the MCO that the member transfers to, as of the effective date of the enrollment.
- **Inpatient Transfer:** For MCO enrollees receiving inpatient care at the time of enrollment and who transfer inpatient facilities as part of the same admission, coverage of services provided after the effective date of enrollment will be the responsibility of BMS. If a patient is discharged and admitted to another inpatient facility, coverage of services provided at the inpatient care facility will be the responsibility of the MCO.

Maternity

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

Excluded Providers

Federal financial participation is not available for excluded providers except for emergency services.

Authorized, Non-Emergency Out-of-Network Services

Unless otherwise negotiated, the MCO shall reimburse providers at the prevailing Medicaid fee-for-service rate for authorized, non-emergency out-of-network services.

7.5 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.

8. ADDITIONAL REQUIREMENTS

8.1 Fraud and Abuse Guidelines

General Requirements

The MCO must have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse. The

procedures must include a method to verify with a sample of enrollees whether billed services were received. The MCO must submit its compliance plan by October 1 of each contract year. The compliance plan includes policies and procedures to prevent, detect, investigate, and report potential fraud and abuse incidences as outlined by BMS. Funds misspent due to fraudulent or abusive actions by the organizations or its subcontractors will be recovered. The MCO will 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 fraud and abuse practices.

Internal Fraud and Abuse Plans

The MCO must have in place internal controls, policies, and procedures to prevent and detect fraud and abuse. The MCO must have a formal fraud and abuse plan with clear goals, assignments, measurements, and milestones. The MCO's fraud and abuse 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 Federal and State standards;
2. The designation of a compliance officer and a compliance committee that are accountable to senior management;
3. Effective training and education for the compliance officer and the organization's employees;
4. Effective lines of communication between the compliance officer and the organization's employees;
5. Enforcement of standards through well-publicized disciplinary guidelines;
6. Provision of internal monitoring and auditing; and
7. Provision for prompt response to detected offenses, and for development of corrective action initiatives.

The plan should also include procedures for:

1. Conducting regular reviews and audits of operations to guard against fraud and abuse;
2. Verifying whether services reimbursed were actually furnished to members, as required in 42 CFR 455.1;
3. Assigning and strengthening internal controls to ensure claims are submitted and payments are made properly;
4. Educating employees, network providers, and beneficiaries about fraud and abuse and how to report it;
5. Effectively organizing resources to respond to complaints of fraud and abuse;
6. Establishing procedures to process fraud and abuse complaints by the MCO;
7. Establishing procedures for reporting information to BMS; and

8. Developing procedures to monitor service patterns of providers, subcontractors, and beneficiaries.

The MCO must monitor provider fraud for underutilization of services and beneficiary/provider fraud for overutilization of services. Monitoring should include:

1. Identifying provider fraud and abuse by reviewing for:
    - A lack of referrals;
    - Improper coding (upcoding and unbundling);
    - Billing for services never rendered; or
    - Inflating bills for services and/or goods provided.
2. Identifying beneficiary fraud by reviewing:
    - Access to services;
    - Patterns of self-referral;
    - Inappropriate emergency care; or
    - Card-sharing.

Coordination

The MCO must take part in coordination activities within the state to maximize resources for fraud and abuse issues. The MCO must meet regularly with BMS, the MFCU and the EQRO to discuss plans of action, and attend fraud and abuse training sessions as scheduled by the state. MCO reporting procedures and timelines for abuse complaints and outcomes must meet state-established guidelines. The MCO must submit a report to BMS by the 15th of each month regarding any suspected fraud and abuse cases identified during the prior calendar month. The report must include the following for each instance that warrants investigation:

- Name/ID number;
- Source of complaint;
- Type of provider;
- Nature of complaint;
- Approximate dollars involved; and
- Legal and administrative disposition of case.

If the MCO does not identify any suspected cases of fraud and abuse during the prior month, the MCO must submit the report stating that it did not identify any suspected cases of fraud and abuse for that period.

Once an MCO has referred a case of suspected fraud and abuse to BMS, the MCO should not take further action against the provider or beneficiary to avoid compromising any law

enforcement investigation. BMS will inform the MCO of the status and outcome of any fraud and abuse investigation referred by the MCO.

The MCO must comply with requests from BMS or the MFCU within 14 days, unless otherwise agreed upon, for access to and copies of any records, computerized data, or information kept by MCO providers to which BMS is authorized to have access.

Prevention and Detection

Key MCO personnel (e.g., owners, directors) must meet state requirements for experience, licensure, and other ownership requirements as outlined in Article II of this contract.
The MCO must regularly submit encounter data as requested by BMS, as well as other data specified in Article III, Section 5.11 of this contract. All other terms and conditions of the original Purchase of Service Contract shall remain unchanged and in full force and effect.

False Claims Acts

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 false claims recoveries.

9. DELEGATION

The MCO oversees and is accountable for any functions or responsibilities that are described in this contract that are delegated to other entities; and shall 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.

Exhibit A
Description of Covered and Excluded Services

The following charts present an explanation of the medical services which the MCO is required to provide; however, the Medicaid 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 fee-for-service 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 Mountain Health Choices, the Medicaid redesign program. Beneficiaries that are not covered under Mountain Health Choices will receive the traditional benefit package. Beneficiaries that are covered under Mountain Health Choices will receive either the basic or enhanced benefit package. The following charts present the covered services under each of these benefit packages.

MCO Covered Services for the Traditional Benefit Package

The following chart presents the covered services under the traditional benefit package for those not participating in Mountain Health Choices (e.g., pregnant women).

MCO Covered Services for the Traditional Benefit Package

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.
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..

MEDICAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
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.	
Dental Services (Adult)	Services provided by a dentist, orthodontist, or oral surgeon.	Emergency services.	Adult coverage limited to treatment of fractures of mandible and manilla, biopsy, removal of tumors, and emergency extractions. TMJ surgery and treatment not covered for adults.
Certain Inpatient and Outpatient Dental Services (Children < 21)	Certain services provided in an inpatient or outpatient setting by a dentist, orthodontist or oral surgeon (not listed as covered under fee-for-service Medicaid).	Emergency, diagnostic, preventive restorative procedures, and prosthodontics.	Provided to individuals under age 21. Services provided by a dentist, orthodontist or oral surgeon or dental group are provided under fee-for-service Medicaid.
Early and Periodic Screening, Diagnoses and Treatment (EPSDT)	Early and periodic screening and diagnostic services to determine psychological or physical conditions in recipients under age 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.	Limited to individuals under age 21.
Family Planning Services & Supplies	Services to aid recipients of child bearing age to voluntarily control family size or to avoid or delay an initial pregnancy.	Family planning clinics, private physicians, services, and supplies.	Sterilization is not covered for recipients under age 21, for recipients 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.
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.	Specialty medical care, diagnosis and treatment.	Services are provided to children under 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 recipients' 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 recipient has a life expectancy of 6 months or less. Recipient waives right to other Medicaid services related to the terminal illness.
Hospital Services, Inpatient	Hospital services, provided for all recipients on an inpatient basis under the direction of a physician.	All inpatient services, including bariatric surgery, and organ transplant services for kidney, kidney/pancreas, liver, bone marrow, cornea, lung, heart, heart/lung, small intestine, and multi-visceral transplants.	Excludes those adults in institutions for mental diseases. 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.

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.
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.	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 recipients under age 21 Certain procedures may have service limits, or require prior authorization.Augmentation communication devices limited to children under 21 years of age and require prior approval.
Physician Services	Services of a physician to a recipient 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. Physician services may be delivered using telehealth.	Certain procedures may have service limits, or require prior authorization.
Podiatry Services	Foot care services.	Treatment for acute conditions, i.e. infections, inflammations, ulcers, bursitis, etc. Surgeries for bunions, ingrown toe nails. 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.
Private Duty Nursing	Nursing services for recipients 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 required. Limited to children under 21 years of age.
Prosthetic Devices and Durable Medical Equipment	Devices and medical equipment prescribed by a physician to ameliorate disease, illness, or injury.	Medically necessary supplies, orthotics, prosthetics and durable medical equipment.	Certain orthodics, prosthetics, and durable medical equipment require prior approval. Certain procedures have service limits. Medical supplies and durable medical equipment in nursing facilities and ICF/MRs are covered in the per diem paid to these providers. Customized special equipment considered.
Right from the Start Services	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 60 days postpartum and infants less than one year of age.
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.	

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. Out of state prior authorization.
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-exam, lenses, frames, and needed repairs.	Adults limited to medical treatment only. Prescription sunglasses and designer frames are excluded. First pair of eyeglasses after cataract surgery. Contact lenses for adults and children covered for certain diagnosis.

MCO Covered Services for Mountain Health Choices Program

The following charts present the benefit packages under Mountain Health Choices, the Medicaid redesign program, for adults and children. Covered services for both the basic and enhanced benefit packages are presented below. Under Mountain Health Choices, MCO enrollees will receive the enhanced benefit package if they sign the West Virginia Medicaid Member Agreement and agree to a Health Improvement Plan with their PCP. Otherwise, MCO enrollees will receive the basic benefit package.

MCO Covered Services for Mountain Health Choices Program – Adults

Basic (Adult)	Enhanced (Adult)
*Inpatient Services • Inpatient Hospital Care	*Inpatient Services • Inpatient Hospital Care
Outpatient Services • *Diagnostic x-ray, laboratory services and testing • *Occupational therapy • *Physical therapy • *Speech therapy • Dental Services (Emergent Treatment)	Outpatient Services • *Diagnostic x-ray, laboratory services and testing • *Occupational therapy • *Physical therapy • *Speech therapy • Dental Services (Emergent Treatment) • Weight Management • *Cardiac Rehabilitation • *Pulmonary Rehabilitation
Physician/Nurse Practitioner/Midwife Services RHC/FQHC • Primary Care Office Visits • Physician Office Visits *Specialty Care	Physician/Nurse Practitioner/Midwife Services RHC/FQHC • Primary Care Office Visits • Physician Office Visits *Specialty Care *Podiatry • Diabetes Educational/Nutritional Counseling
Home Health (prior authorization after 60 units)***	Home Health (prior authorization after 60 units)***
DME (limited $1000 per year with prior authorization if exceeded)*** • Orthotics and Prosthetics**	DME** • Orthotics and Prosthetics**
Family Planning Services and Supplies	Family Planning Services and Supplies
*Hospice	*Hospice
Ambulance	Ambulance
	Chiropractic Services***
	Tobacco Cessation Program
	Nutritional Education

*Prior authorization for medical necessity only
**Prior authorization for medical necessity, subject to service limitations listed in BMS provider manuals at www.wvdhhr.org/bms.
***Prior authorization based on medical necessity to exceed limits

MCO Covered Services for Mountain Health Choices Program – Children

Basic (Children)	Enhanced (Children)
*Inpatient Services • Inpatient Hospital Care • Inpatient Hospital Rehabilitation	*Inpatient Services • Inpatient Hospital Care • Inpatient Hospital Rehabilitation
Outpatient Services • *Diagnostic x-ray, laboratory services and testing • *Occupational therapy • *Physical therapy • *Speech therapy • *Cardiac Rehabilitation • *Pulmonary Rehabilitation	Outpatient Services • *Diagnostic x-ray, laboratory services and testing • *Occupational therapy • *Physical therapy • *Speech therapy • *Cardiac Rehabilitation • *Pulmonary Rehabilitation • Weight Management
Physician/Nurse Practitioner/Midwife Services RHC/FQHC • Primary Care Office Visits • Physician Office Visits *Specialty Care *Podiatry • Diabetes Educational/Nutritional Counseling • Well Child Visits	Physician/Nurse Practitioner/Midwife Services RHC/FQHC • Primary Care Office Visits • Physician Office Visits *Specialty Care *Podiatry • Diabetes Educational/Nutritional Counseling • Well Child Visits
Home Health (prior authorization after 60 units)***	Home Health (prior authorization after 60 units)***
DME** • Orthotics and Prosthetics**	DME** • Orthotics and Prosthetics**
EPSDT	EPSDT
Family Planning Services and Supplies	Family Planning Services and Supplies
*Hospice	*Hospice
Ambulance	Ambulance
Vision Limited 1 frame/yr***	Vision *Contact Lenses Limited 1 frame/yr***
Certain Dental Services****	Certain Dental Services****
Hearing 1 hearing aid/5 yrs***	Hearing 1 hearing aid/5 yrs***
Tobacco Cessation Program	Tobacco Cessation Program
*Skilled Nursing Care	*Skilled Nursing Care
	Nutritional Education

*Prior authorization for medical necessity only
**Prior authorization for medical necessity, subject to service limitations listed in BMS provider manuals at www.wvdhhr.org/bms.
***Prior authorization based on medical necessity to exceed limits
****Certain services provided to individuals under age 21 in an inpatient or outpatient setting by a dentist, orthodontist, or oral surgeon (not listed as covered under fee-for-service Medicaid). Prior authorization for medical necessity, subject to service limitations listed in BMS provider manuals at www.wvdhhr.org/bms.

Medically necessary services, as set forth in the Social Security Act, Section 1905 (42 USC 1396d(a)) and identified by an interperiodic or periodic EPSDT (early and periodic screening, diagnostic and treatment services) screen will be provided either at the medical home or referred to an appropriate provider.

NOTE: If federal government rules or West Virginia state law should change such that Medicaid covered services are altered, such changes will flow through to the MCO contract and payment will be modified accordingly.

Services that are experimental, unsafe, or generally not recognized as an accepted method of medical practice or treatment are not covered. Supplies, items, or equipment determined to be non-medical in nature are not covered.

Medicaid Benefits Covered Under Fee-For-Service 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 fee-for-service basis. The State may consider the use of specialized carveouts in the future.

Medicaid Benefits Covered Under Fee-For-Service 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 actopic pregnancy.	Written physician certification of medical necessity. All Federal and State laws regarding this benefit must be adhered to.
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, and other program services for individuals with mental illness, mental retardation, and substance abuse.	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.
Dental Services (Children < 21)	Services provided by a dentist, orthodontist or oral surgeon or dental group to children under the age of 21.	Emergency, surgical, diagnostic, preventive, and restorative treatment, periodontics, endodontics, orthodontics, prosthodontics, extractions, and complete or partial dentures.	Limited to individuals under age 21.
Early Intervention Services for Children Three Years and Under	Early intervention services provided to children three years and under through the Birth to Three program.	Services provided by enrolled Birth to Three providers.	
Behavioral Health Rehabilitation for Individuals Under Age 21, Residential Treatment	Behavioral health rehabilitation perfomed in a children's residential treatment facility.	Diagnosis, evaluation, therapies, and other program services for individuals with mental illness, mental retardation, and substance abuse.	Procedure specific limits on frequency and units.
ICF/MR-Intermediate Care Facility for the Mentally Retarded	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, pharmacy, 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. Recipient must be certified as needing ICF/MR level of care by physician and psychologist. Limited to the first 30 days.
Nursing Facility Services	Facility based nursing services to those who require 24 hour nursing level of care.	Full range of nursing, social services and therapies.	Not covered.

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 Eligibity Assessment (PCMEA) or are not in the approved plan of medically necessary care developed by the registered nurse, hours that exceed the 60 hours per member per month limitation that have not been prior authorized, services provided by a member'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 an independent 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. Drugs and supplies dispensed by a physician acquired by the physician at no cost are not covered.
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.	Prior authorization is required for services beyond ten. Evaluation and testing procedures have frequency restrictions.
Hospital Services, Inpatient – Behavioral Health and Substance Abuse Stays	Inpatient hospital services related to the treatment of mental disorders or substance abuse disorders.	Inpatient stays with a DRG of 425-433 or 521-523 or MS-DRG 880-887 or 894-897.	NA
Inpatient Psychiatric Services for Individuals Under Age 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 21.	Active treatment of psychiatric condition through an individual plan of care including post discharge plans for aftercare. Service is expected to improve the recipient'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 recipient. Pre-admission and continued stay prior authorization.
School-based Psychological Services	Services provided by a licensed psychologist in the treatment of psychological conditions in a school-based setting.	Evaluation and treatment, including individual, family, and group therapies.	Prior authorization is required for services beyond ten. Evaluation and testing procedures have frequency restrictions.
Transportation, Non-emergency	Non-ambulance medical transporation to and from Medicaid covered scheduled medical appointments.	Includes transporation via multi-passenger van services and common carriers such as public railways, buses, cabs, airlines, and private vehicle transporation by individuals.	Prior authorization by BMS is required for multi-passenger van services. Prior authorization by county DHHR staff is required for transporation by common carriers.

Abortion Services

Under the terms of this Agreement, BMS will reimburse the MCO according to the established Medicaid rates, fee schedules, and payment methodologies for the services provided to Mountain Health Trust enrollees under certain reported and verified abortion CPT codes. MCOs can obtain a list of these codes from BMS. MCOs must submit payment requests in a format acceptable to BMS.

Court-Ordered Services

The MCO is required to reimburse providers for court-ordered treatment services that are included in the MCO covered services as part of the Traditional, Basic, and Enhanced benefit packages, regardless of whether the MCO finds that the service is medically necessary; the court order would serve as a binding determination of medical necessity.

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.

Exhibit C
Service Area

Carelink's service area consists of the following counties:

County	Full Risk Managed Care Only (Choice of Managed Care Organizations or Rural Option)	Choice of Managed Care Organization or PAAS*
Barbour	X	
Berkeley	X	
Boone	X	
Braxton	X	
Brooke	X	
Cabell	X	X
Calhoun	X	
Clay	X	
Doddridge	X	
Fayette	X	
Gilmer	X	
Greenbrier	X	
Hampshire	X	
Hancock	X	
Harrison	X	
Jackson	X	
Jefferson	X	
Kanawha	X	
Lewis	X	
Lincoln	X	
Logan	X	
Marion	X	
Marshall	X	
Mason	X	
McDowell	X	
Mercer	X	
Mingo	X	
Mineral	X	
Monongalia	X	
Monroe	X	
Morgan	X	
Nicholas	X	
Ohio	X	
Pleasants	X	
Pocahontas	X	
Preston	X	
Putnam	X	
Raleigh	X	
Randolph	X	

County	Full Risk Managed Care Only (Choice of Managed Care Organizations or Rural Option)	Choice of Managed Care Organization or PAAS*
Ritchie	X	
Roane	X	
Summers	X	
Taylor	X	
Tucker	X	
Tyler	X	
Upshur	X	
Wayne		X
Webster	X	
Wetzel	X	
Wirt	X	
Wood	X	
Wyoming	X	

* PAAS is the Department's primary care case management program

Exhibit D
BMS Marketing Guidelines

Managed care organizations (MCOs) will be allowed to conduct general advertising that does not specifically solicit the Medicaid population. MCOs will not be allowed to complete enrollment forms on behalf of beneficiaries. This function will rest with the enrollment broker. The following activities will be expressly forbidden:

- MCOs may not assert or imply that a beneficiary will lose Medicaid benefits if he/she does not enroll in the organization's plan.
- MCOs may not assert or imply that the MCO is endorsed by CMS, the federal or state government, or similar entity.
- MCOs may not discriminate (in marketing to or during the course of enrollment) against any eligible individual on the basis of health status or need for future health care services.
- MCOs may not market or advertise a benefit or service unless it is clearly specified in the contract and available throughout the enrollment period.
- MCOs may not market to or conduct surveys of members who have initiated disenrollment from their plan prior to the effective date of the disenrollment. Any post-disenrollment survey tools or methodologies must be prior-approved by BMS.

Mailings must include adequate written description of organization's rules, procedures, benefits, limitations, services, and other information.

The table on the following page presents parameters for health plan marketing, and uses the following terms:

- Direct marketing materials: all media, including brochures and leaflets; newspaper, magazine, radio, television, billboard and yellow pages advertisements; and presentation materials used by plan representatives.
- Medicaid-specific marketing: any materials mailed to, distributed to, or aimed at Medicaid recipients specifically, and any material that mentions Medicaid or Title XIX.
- Gifts: pertinent items (e.g., magnet with immunization schedule) of nominal dollar value. Gifts to enrollees may include gift cards. The gift cards may only be issued to members in connection with their participation in MCO initiatives in the areas of health education or improved medical outcomes (e.g., reward for participation in MCO prenatal program). The value of each gift card may not exceed $10 and gift cards may not exceed $50 in fair-market value per enrollee over a twelve-month period. The gift cards may not be converted to cash.

Type of Marketing Activity	Permitted, BMS Approval Not Needed	Permitted, With BMS Content Approval	Not Permitted
General, non-Medicaid advertising	X		
General, Medicaid-specific advertising		X	
Medicaid-specific advertising in current care sites or at eligibility offices			X
Enrollee-initiated requests for phone conversation with plan staff	X		
Enrollee-initiated one-on-one meetings with plan staff prior to enrolling			X
Mailings by plan in response to enrollee requests		X	
Unsolicited MCO mailings to enrollees			X
MCO group meetings prior to enrolling			X
Individual solicitation			X
Gifts, cash incentives, or rebates (anything other than written information about the plan or general health education information) to potential enrollees			X
Gifts to enrollees after they enroll, simply because they enroll			X
Marketing or advertising a benefit or service that is not clearly specified in the contract and/or is not available throughout the enrollment period			X
Gifts to enrollees (e.g. gift card, baby T-shirt showing immunization schedule) based on specific health events unrelated to enrollment		X	

Exhibit E
Summary of MCO Reporting Requirements

Reporting Requirement	Timeframe				
	Monthly	Quarterly	Annually	Other	Due Date
Quarterly reports					
MHT-1: Enrollment and Membership Report		X			Within 45 days of end of quarter
MHT-2: PCP Panel Report		X			
MHT-3: Control totals for Monthly Encounter Data Electronic Submission		X			
MHT-4: Experience Summary		X			
MHT-5: Grievance Report		X			
MHT-6: Lag Tables		X			
MHT-7: Summary of Claims Paid Outside Encounter Data and Sub-Capitation Arrangements		X			
MHT-7a: Experience Summary for Capitated Arrangements		X			
MHT-8: Summary of Total Dollars		X			
MHT-9: Third Party Liability Collections		X			
MHT-10: Grievance Report for Children with Special Health Care Needs		X			
MHT-11: Member and Provider Services Functions		X			
MHT-12: Mountain Health Choices		X			
MHT-13: EPSDT Reporting		X			
MHT-14: Medicaid-Related Financial Reports		X			
Quality					
Written description of PIPs and results			X		To be determined
HEDIS			X		On or before June 15 (unaudited)
QAPI			X		As required by BMS
QAPI – status and results				X	As required by BMS
QIPs based on EQRO					To Delmarva within 1 month of EQRO report
CAHPS member survey			X		On or before June 15
Medicare and private accreditation review report				X	Upon request
Encounter data	X				Within 30 days of end of month
Providers					
Provider network data	X				Electronic provider directories to be submitted to AHSI monthly
Provider network adequacy				X	Upon significant changes to service area, etc.

Reporting Requirement	Timeframe				
	Monthly	Quarterly	Annually	Other	Due Date
Financial reporting					
Annual financial statements			X		On or before June 1
Department of Insurance reports – quarterly and annually		X	X		Concurrent with DOI submission
Inpatient Paid Claims Report		X			Within 40 days of end of quarter
Third Party Liability Cases Not Pursued	X				The 15th of each month (to include all events from the prior month)
Provider-Preventable Conditions					To Be Determined
Data for Drug Rebate Collection	X				Within 15 days of end of each month
Federal reporting					
Abortions				X	Submit attestation by October 1
Hysterectomies and Sterilizations				X	Submit attestation by October 1
EPSDT Services and Reporting				X	Submit attestation by October 1
Providers Denied Credentialing/Suspended/ Terminated	X				The 15th of each month (to include all events from the prior month)
Fraud and Abuse Reporting	X				The 15th of each month (to include all events from the prior month)
Disclosure of Ownership Reporting			X		On or before October 1
Business Transactions of Contracted Providers Reporting			X		On or before October 1
Fraud and Abuse Compliance Plan			X		On or before October 1
FQHC/RHC quarterly payment reports		X			Within 45 days of end of quarter
Other State Required Reporting					
Sexually Transmitted Diseases			X		Submit attestation by October 1
Tuberculosis			X		Submit attestation by October 1
Communicable Diseases			X		Submit attestation by October 1
Marketing Plan			X		On or before October 1

Exhibit F
Data Certification Form

STATE OF WEST VIRGINIA
MOUNTAIN HEALTH TRUST
DATA CERTIFICATION FOR _____REPORT SUBMISSION

Date Of Data Submission^: _____
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)).