

**PURCHASE OF SERVICE PROVIDER AGREEMENT**

**BETWEEN**

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

**AND**

**MANAGED CARE ORGANIZATION**

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

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**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 **HEALTH PLAN**, 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 or the Mountain Health Trust and West Virginia Health Bridge Medicaid MCO Provider Application, (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 will 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 will also be deemed to mean the plural and vice-versa. Titles of paragraphs used herein are for the purpose of facilitating ease of reference only and will not be construed to be a part of this contract.

## **2. CONTRACT TERM**

The initial term of this contract will commence on July 1, 2015 and will be effective through June 30, 2016, 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 will not exceed 12 months. The contract will 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, 2015, through June 30, 2016. 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 must 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 will 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 will have any force or effect unless it is in writing and duly executed by the parties. Said modification will be incorporated as a written amendment to the contract.

## **4. CONTRACT ADMINISTRATION**

This contract will be administered for the State by 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 will serve as Contracting Officer upon the execution of the contract. The Contracting Officer will be responsible for all matters related to this contract.

## **5. NOTICES**

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

Managed Care Organization

Department

Cynthia E. Beane, Acting Commissioner  
Bureau for Medical Services  
350 Capitol Street  
Charleston, West Virginia 25301

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

All questions, requests, and other matters related to the administration of this contract must be addressed with Jeff Wiseman to be considered. Mr. Jeff Wiseman contact information is below.

Jeff Wiseman  
Assistant to the Deputy Secretary  
West Virginia Department of Health and Human Resources  
1 Davis Square, Suite 100E  
Charleston, WV 25301  
304-558-6052 (office phone)  
[Jeff.A.Wiseman@wv.gov](mailto:Jeff.A.Wiseman@wv.gov)



## ARTICLE II: GENERAL CONTRACT TERMS FOR MANAGED CARE ORGANIZATIONS

### 1. DEFINITIONS

As used throughout this contract, the following terms will have the meanings set forth below.

Abuse – provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

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 as required by the contract; 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.

Behavioral Health Services -services used to treat a mental illness, behavioral disorder and/or substance use disorder which necessitates therapeutic and/or supportive treatment, such services include but not limited to psychological and psychiatric services.

Business Continuity Plan (BCP) – a plan that provides for a quick and smooth restoration of the MCO information system after a disruptive event. BCP includes business impact analysis, BCP development, testing, awareness, training, and maintenance. This is a day-to-day plan.

CAHPS – the Consumer Assessment of Health Plans Survey. This survey is conducted annually by the EQRO.

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.

Cardiac Rehabilitation - A comprehensive outpatient program of medical evaluation, prescribed exercise, cardiac risk factor modification, and education and counseling that is designed to restore members with heart disease to active, productive lives.

Clinical Edit – a process for verifying that a member’s medical condition matches the clinical criteria for dispensing a requested drug. Clinical Edits must be based on evidence-based clinical criteria.

Cold-Call Marketing – any unsolicited personal contact by the MCO with a potential member for the purpose of influencing the potential member to enroll in that particular MCO. Cold Call Marketing includes, without limitation:

- Unsolicited personal contact with a potential member outside of an enrollment event, such as door-to-door or telephone marketing.
- Any marketing activities at the enrollment events where participation is mandatory.
- Any other personal contact with a potential member if the potential member has not initiated the contact with the MCO.

Common area (Marketing) – any area in a provider’s facilities that is accessible to the general public. Common areas include, without limitation: reception areas, waiting rooms, hallways, etc.

Complaint – an expression of dissatisfaction made about an MCO decision or services received from the MCO when 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.

Corrective Action – an improvement in a business process that may be required by the Department to correct or resolve a deficiency in the MCO’s processes or actions.

Covered Services (Contract Services) - health care services the MCO must arrange to provide to Medicaid members, including all services required by this contract and state and federal law, and all Value-Added Services negotiated by the MCO and the Department.

CMS – the Centers for Medicare and Medicaid Services, a division within the federal Department of Health and Human Services.

Corrective Action Plan – a detailed written plan that may be required by the Department to correct or resolve a deficiency in the MCO’s processes or actions.

Cost-Sharing - Copays that the MCO enrollee is billed at the time of service. Copays are determined by the Department based on the member’s family income. There are no premiums, deductibles or other cost-sharing obligations under the West Virginia Medicaid program.

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.

Direct Mail Marketing - any materials sent to potential members by the MCOs or their agents through U.S. mail or any other direct or indirect delivery method.

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. EPSDT entitles Medicaid-eligible infants, children, and adolescents to any treatment or procedure that fits within any of the categories of Medicaid-covered services listed in Section 1905(a) of the Social Security Act if that treatment or service is necessary to “correct or ameliorate” defects and physical and mental illnesses or conditions.<sup>1</sup>

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

Emergency Dental Condition - A dental or oral condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson possessing an average knowledge of health and medicine requires immediate services for relief of symptoms and stabilization of the condition; such conditions may include severe pain, hemorrhage, acute infection, traumatic injury to the teeth and surrounding tissue, or unusual swelling of the face or gums.

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

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.

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<sup>1</sup>Section 1905(r)(5) of the Social Security Act

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.

Gift (Marketing) – any promotional item or incentive offered by an MCO to members or potential members.

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.

Information Security Plan – a written MCO compliance plan with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and The Health Information Technology for Economic and Clinical Health Act (HITECH Act).

Health Home - a designated provider (including provider that operates in coordination with a team of health care professionals) or a health team selected by an eligible individual to provide health home services as defined in Section 1945 of the Social Security Act. Chronic condition health homes are available for eligible individuals with certain chronic conditions. West Virginia’s requirements for health homes are defined in the Medicaid State Plan.

HEDIS – the Health Plan Employer Data and Information Set developed, sponsored and maintained by NCQA. HEDIS is a set of standardized performance measures designed to reliably compare the performance of managed care health plans.

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

Liquidated Damages – reasonable estimates of the Department’s projected financial loss and damage resulting from the MCO’s non-performance.

Lock-in Program (Pharmacy) – a process of controlling the inappropriate use of pharmacy services by MCO members. The MCO assigns its member to a single pharmacy if he/she received duplicative, excessive, or conflicting pharmacy services, or if MCO review shows abuse, misuse, or suspected fraudulent member actions related to pharmacy services.

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.

Managing Employee – a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency, in accordance with 42 CFR 455.101.

Marketing – any communication, from the MCO to a Medicaid-eligible person who is not enrolled in the MCO, that can reasonably be interpreted as intended to influence such person to enroll in that particular MCO’s Medicaid program, or either to not enroll in, or to disenroll from, another MCO’s Medicaid program.

Maximum Allowable Cost- means the upper limit or maximum amount that the MCO will pay for generic prescription drugs or brand-name prescription drugs with available generic versions, which are included on a list of products generated by the MCO [or on the MCO’s behalf](#).

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.

Medical Loss Ratio - the ratio of the sum of total medical expenses and the total capitation revenue, including monthly capitation and delivery kick payments, received by the MCO and subject to any applicable adjustments, as provided under this Contract and Exhibit I.

Mountain Health Trust – the name of West Virginia’s Medicaid mandatory managed care program for TANF and TANF-related children and adults who are eligible to participate in managed care.

National Committee for Quality Assurance (NCQA) – the independent organization that accredits MCOs, managed behavioral health organizations, and accredits and certifies Disease Management programs.

Non-Emergency Services - Any care or services that are not considered emergency services as defined in this Contract. This does not include any services furnished in a hospital emergency department that are required to be provided as an appropriate medical screening examination or stabilizing examination and treatment under section 1867 of the Social Security Act.

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).”

Periodicity Schedule – the requirements and frequency by which periodic screening services are provided and covered. Schedule must meet current standards of pediatric medical and dental practice and specify screening services applicable at each stage of the recipient's life, beginning with a neonatal examination, up to the age at which an individual is no longer eligible for EPSDT services.

Pharmacy Benefit Manager (PBM) – a third party administrator of prescription drug programs.

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.

Preferred Drug List (PDL) – a part of the MCO formulary managed by the Department. It contains a list of drugs with preferred or non-preferred status as recommended to the Department by the Medicaid Pharmaceutical and Therapeutics (P & T) Committee and approved by the Secretary of the Department of Health and Human Resources. The drugs that are indicated as "preferred" have been selected for their clinical significance and overall efficiencies. The MCO is required to follow the guidance provided in the PDL.

Pregnant Women or Pregnancy-Related Services – All women receiving related services and services for other conditions that might complicate the pregnancy, unless specifically identified in the State Plan as not being related to the pregnancy. This includes counseling and drugs for cessation of tobacco use and services during the postpartum period. The pregnancy period for which these services must be covered includes the prenatal period through the postpartum period (including the 60-day postpartum period following the end of pregnancy; see 42 CFR 440.210(a)(3)).

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

Primary Services – basic or general health services rendered by general practitioners, family practitioners, internists, obstetricians, and pediatricians.

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.

Pulmonary Rehabilitation - Individually tailored multidisciplinary approach to the rehabilitation of members who have pulmonary disease.

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.

Risk Corridor- is a temporary contractual feature applied to the West Virginia Health Bridge program under which the MCO will participate in a payment adjustment system based on the ratio of the medical expenses of the MCO as defined by Exhibit I to the MCO's aggregate capitation premiums. Service Authorization – (also 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.

Subcontractor Monitoring Plan - a written plan describing how obligations, services, and functions performed by the MCO's subcontractor will be reviewed to ensure that such obligations, services, and functions are performed to the same extent that they were performed by MCO.

Systems Quality Assurance Plan - a written plan developed by the MCO that describes the processes, techniques, and tools that the MCO will use for assuring that the MCO information systems meet the Contract requirements.

Tertiary Services - highly specialized medical services administered in a specialized medical facility.

Third Party - any individual entity or program which is or may be liable to pay all or part of the expenditures for Medicaid furnished under a State Plan.

Title XIX - refers to Title XIX of the Social Security Act codified at 42 United States Code Annotated Section 1396 et. seq., including any amendments thereto (see Medicaid).

Value-Added Services - services that include additional value benefits that are actual health care services, benefits, or positive incentives that will promote healthy lifestyles and improve health outcomes among members.

West Virginia Health Bridge (WVHB) - the name of West Virginia's mandatory managed care program for adults eligible for the Medicaid Alternative Benefit Plan (ABP).

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 will relieve either party of responsibility for carrying out the terms of the contract.

## **3. FUNCTIONS AND DUTIES OF THE MANAGED CARE ORGANIZATION**

The MCO agrees to perform the functions and duties and fulfill the responsibilities described in Article III, Statement of Work.



## **4. FUNCTIONS AND DUTIES OF THE STATE**

### **4.1 Eligibility Determination**

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 secure File Transfer Protocol or 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.

### **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 delivery system.

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).

The MCO must supply all necessary information to the enrollment broker regarding the Department's enrollee lock-in program implemented in accordance with 42 CFR 438.56.

### **4.4 Capitation Payments to Managed Care Organization**

Payment to the MCO will 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 members who appear on only one of the two sources. The MCO will be responsible for detecting the source of the inconsistency between the enrollment data and the MCO monthly claims invoice. The MCO must notify the Department in writing of any inconsistency between enrollment and payment data no later than within 45 days from the day inconsistency was determined by the MCO. 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 as soon as administratively possible. The adjusted payment (representing reinstated members) for each month of coverage will be included in the next

monthly capitation payment, based on updated MCO enrollment information for that month of coverage.

Any retrospective adjustments to prior capitations will be made in the form of an addition to or subtraction from the current month's capitation payment. Positive adjustments are particularly likely for newborns, where the MCO may be aware of the birth before 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, 2015, through June 30, 2016 (State Fiscal Year 2016). State Fiscal Year 2017 capitation payments will be determined by the Department no later than April 15, 2016, or upon CMS approval whichever is later. If the Department does not provide the capitation rates to the MCO by April 15, 2016, or upon CMS approval, 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.

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 Enrollee Eligibility Capitation Adjustments**

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

The MCO 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 Enrollee Reinstatement Processing**

Medicaid recipients who lose eligibility for the West Virginia Mountain Health Trust or West Virginia Health Bridge programs and regain eligibility within one year 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 one year, the recipient will select a MCO through the standard enrollment broker enrollment process.

#### **4.7 Information**

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

The Department will notify the 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.

#### **4.8 Ongoing Managed Care Organization Monitoring**

To ensure the quality of care, the Department will undertake the following monitoring activities including, but not limited to:

1. Analyze the MCO's access enhancement programs, financial and utilization data, and other reports to monitor the value the MCO is providing in return for the State's capitation revenues. Such efforts will include audits of the MCO and its subcontractors. .
2. Conduct regular 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 monitoring activities 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 will waive any current Department fee-for-service requirements for prior authorization, second opinions, or other fee-for-service Medicaid restrictions for the provision of those contract services provided by the MCO to enrollees, except when such requirements are provided by State or Federal law or by the State Plan.

#### **4.10 Force Majeure**

The MCO will be excused from performance hereunder for any period that it is prevented from providing, arranging for, or paying for services as a result of a catastrophic occurrence or natural disaster including but not limited to an act of war, and excluding labor disputes.

#### **4.11 Time Is of the Essence**

In consideration of the need to ensure uninterrupted and continuous MCO performance and service delivery, time is of the essence in the performance of the obligations under this Contract.

#### **4.12 MCO Response Time Frames**

The MCO must submit required reports, documentation, ad hoc reports, data certification forms, or any other data required within the time frames provided by this Contract or by the Department. If an MCO does not submit a required or ad hoc report, documentation, data certification form, or data required to meet any State or Federal reporting requirements (e.g., drug utilization data, provider-preventable conditions) to the Department within the timeframes outlined in this contract or in the Department's request, the Department may assess damages on the MCO. The MCO may have a one business day grace period following the due date of the data, report, documentation, or data certification form. However, for each additional day an item is overdue beyond the grace period, the Department may assess damages on the MCO as outlined in Article II, Section 6 and Exhibit H.

### **5. DECLARATIONS AND MISCELLANEOUS PROVISIONS**

#### **5.1 Competition Not Restricted**

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

#### **5.2 Binding Authority**

Each MCO representative signing the contract must submit written certification along with the signed contract that he/she is the person in the organization responsible for, or authorized to make, decisions regarding this contract.

### **5.3 Nonsegregated Facilities**

The MCO certifies that it does not and will not maintain or provide for its employees any segregated facilities at any of its establishments, and that it does not permit its employees to perform their services at any location, under its control, where segregated facilities are maintained. The MCO agrees that a breach of this certification is a violation of Equal Opportunity in Federal employment. In addition, the MCO must comply with the Federal Executive Order 11246 entitled "Equal Employment Opportunity" as amended by Executive Order 11375 and as supplemented in the United States Department of Labor Regulations (41 CFR Part 30). As used in this certification, the term "segregated facilities" includes any waiting rooms, restaurants and other eating areas, parking lots, drinking fountain, recreation or entertainment areas, transportation, and housing facilities provided for employees which are segregated on the basis of race, color, religion, or national origin, because of habit, local custom, national origin, or otherwise.

The organization further agrees (except where it has obtained identical certifications from proposed subcontractors for specific time periods) that it will obtain identical certifications from proposed subcontractors which are not exempt from the provisions for Equal Employment Opportunity; that it will retain such certifications in its files; and that it will forward a copy of this clause to such proposed subcontractors (except where the proposed subcontractors have submitted identical certifications for specific time periods).

### **5.4 Offer of Gratuities**

The MCO warrants that it has not employed any company or person other than a bona fide employee working solely for the MCO or a company regularly employed as its marketing agent to solicit or secure the contract and that it has not paid or agreed to pay any company or person any fee, commission, percentage, brokerage fee, gifts, or any other consideration contingent upon or resulting from the award of the contract.

For breach or violation of this warranty, the Department will have the right to terminate this contract with 30 day notice without liability or, at its discretion to pursue any other remedies available under this contract or by law.

### **5.5 Employment/Affirmative Action Clause**

The MCO agrees to supply employment/affirmative action information as required for agency compliance with Title VI and VII of the Civil Rights Acts of 1964.

### **5.6 Hold Harmless**

The MCO agrees to indemnify, defend and hold harmless the State of West Virginia and 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 will be regarded as confidential information and all necessary steps must be taken by the MCO to safeguard the confidentiality of such material or information in conformance with federal and state statutes and regulations.

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 must act in an independent capacity and must not hold themselves out to be officers or employees of the State of West Virginia or of 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.

### **5.10 Key Staff Positions**

The MCO must 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 must 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 must notify the Department in writing of changes in key staff positions when individuals either leave or fill these key positions within 14 calendar days of any change. The MCO must also provide an updated organizational chart within 14 days of request.

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

### **5.12 Communication with the Department**

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

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

MCO's failure to communicate complete, meaningful, and timely responses to all Department's information requests may result in remedies as described in Article II, Section 6 and Exhibit H of this contract.

### **5.13 Freedom of Information**

Due regard will be given for the protection of proprietary information contained in all applications and documents received; however, MCO applicant should be aware that all materials associated with the MCO application are subject to the terms of the Freedom of Information Act, the Privacy Act and all rules, regulations, and interpretations resulting therefrom. It will not be sufficient for the MCO to merely state generally that the material is proprietary in nature and not therefore subject to release to third parties. Those particular pages of sections which MCO applicant believes to be proprietary must be specifically identified as such.

## **5.14 Waivers**

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

## **5.15 Compliance with Applicable Laws, Rules, And Policies**

The MCO and its subcontractors, in performing this contract, must comply with all applicable Federal and State laws, regulations, and written policies, including those pertaining to licensing and including those affecting the rights of enrollees. MCOs must include provisions relating to compliance with such laws in subcontracts with providers. Assessment of compliance must be included in the MCOs' credentialing procedures to the extent feasible.

Work performed under this contract must conform to the federal requirements set forth in Title 45, CFR Part 74 and Title 42, Part 434. The MCO must also abide by all applicable Federal and State laws and regulations including but not limited to:

- Section 504 of the Rehabilitation Act of 1973;
- Title IX of the Education Amendments of 1972;
- The Age Discrimination Act of 1975;
- Titles II and III of the Americans with Disabilities Act;
- Section 542 of the Public Health Service Act, pertaining to nondiscrimination against substance 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 438 of 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;
- American Disabilities Act of 1990 as amended;
- Patient Protection and Affordable Care Act (PPACA);
- Health Care and Education Reconciliation Act of 2010 (HCERA); and



- Any other pertinent Federal, State or local laws, regulations, or policies in the performance of this contract.

The MCO must comply with all applicable Federal and State laws, regulations, policies, or reporting requirements needed to comply with the policies and regulations set forth in the Patient Protection and Affordable Care Act (PPACA), P.L. 111-148, enacted on March 23, 2010, and the Health Care and Education Reconciliation Act of 2010 (HCERA), P.L. 111-152, enacted on March 30, 2010.

The MCO must also comply with requirements and regulations pertaining to:

- Copyrights, data, and reporting and patent rights under any contract involving research, developmental, experimental, or demonstration work with respect to any discovery or invention which arises or is developed in the course of this contract;
- Applicable standards, orders or requirements under Section 306 of the Clean Air Act (42 USC 1857(h)), section 508 of the Clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR part 15); and
- Energy efficiency which are contained in the State energy conservation plan issued in compliance with the Energy Policy and Conservation Act (P.L. 94-165).

The MCO must procure all necessary permits and licenses and abide by all applicable laws, regulations, and ordinances of the United States, State of West Virginia, and political subdivision in which work under the contract is performed.

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

The MCO must pay any sales tax, use and personal property taxes arising out of this contract and the transactions contemplated thereby. Any other taxes levied upon this contract, the transaction, or the equipment or services delivered pursuant hereto can be borne by the MCO.

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

### **5.16 Non-discrimination**

The MCO must comply with all Federal and State laws relating to non-discrimination, including but not limited to : Title VI of the Civil Rights Act of 1964, (42 U.S.C. §2000d et seq.) and as applicable 45 CFR Part 80 or 7 CFR Part 15; Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794); Americans with Disabilities Act of 1990 (42 U.S.C. §12101 et seq.); Age Discrimination Act of 1975 (42 U.S.C. §§6101-6107); Title IX of the Education Amendments of 1972 (20 U.S.C. §§1681-1688); Food Stamp Act of 1977 (7 U.S.C. §200 et seq.); Executive Order 11246 and its implementing regulations at 41 CFR Part 60; Executive Order 13279, and its implementing regulations at 45 CFR Part 87 or 7 CFR Part 16; The Immigration Reform and Control Act of 1986 (8 U.S.C. §1101 et seq.). The MCO may not discriminate in enrollment, delivery of health care, or any other activity against enrollees on the basis of health status, 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 must comply with those federal requirements and assurances for recipients of federal grants provided in OMB Standard Form 424B which are applicable to the MCO. The MCO is responsible for determining which requirements and assurances are applicable to the MCO. Copies of the form are available from the Department.

The MCO must 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., will not pay federally appropriated funds to any person for influencing or attempting to influence an officer or employee of any agency, a member of the U.S. Congress, an officer or employee of the U.S. Congress, or an employee of a member of the U.S. Congress in connection with the awarding of any federal contract, the making of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

The MCO must submit to 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 must require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients must certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this contract was made and entered into. Submission of this certification is a prerequisite for making and entering into this contract imposed under Section 1352, Title 31, US Code. Any person who fails to file the required certification will be subject to a civil penalty.

### **5.19 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 must make the information reported available to its enrollees upon reasonable request.

The MCO will covenant that it, its officers or members, employees, or subcontractors will not acquire any interest, direct or indirect which would conflict or compromise in any manner or degree with the performance of its services hereunder. The MCO further covenants that in the

performance of the contract, the MCO must periodically inquire of its officers, members, and employees concerning such interests. Any such interests discovered must be promptly presented in detail to the Department.

## **5.20 Department's Data Files**

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

The Department's data will not be utilized by the MCO for any purpose other than that of rendering services to the Department under this contract, nor will 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 must, upon request to the MCO, have the right of access and use of any data files retained or created by the MCO for systems operation under this contract.

The MCO must establish and maintain at all times reasonable safeguards against the destruction, loss, or alteration of 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. CONTRACT REMEDIES AND DISPUTES**

## **6.1 MCO Performance**

The MCO is expected to meet or exceed all the Department's objectives and standards, as set forth in the contract. All areas of responsibility and all contract requirements will be subject to performance evaluation by the Department. A designated representative of the MCO and a designated representative of the Department may meet as requested by either party, to review the performance of the MCO under this contract. Written minutes of such meetings will be kept. In the event of any disagreement regarding the performance of services by the MCO under this contract, the designated representatives must discuss the performance problem and negotiate in good faith in an effort to resolve the disagreement.

For purposes of this contract, an item of non-compliance/non-performance means a specific action of the MCO or its subcontractor, agent and/or consultant that:

- Violates a provision of this contract including Exhibits;
- Fails to meet an agreed measure of performance and/or standard; or
- Represents a failure of the MCO to be reasonably responsive to a reasonable request of the Department for information, assistance, or support within the timeframe specified by the Department.

The Department will consider the following items as contract non-performance, including but not limited to:

- Failing substantially to provide medically necessary services that the MCO is required to provide, under law or under its contract with the Department, to an enrollee covered under the contract;
- Imposing premiums, copays, or charges that are in excess of the premiums, copays, or charges permitted under the Medicaid program;
- Acting to discriminate among enrollees on the basis of their health status or need for health care services, including terminating of enrollment or refusal to reenroll 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;
- Misrepresenting or falsifying information that the MCO furnishes to CMS or to the State;
- Misrepresenting or falsifying of information that the MCO furnishes to an enrollee, potential enrollee, or health care provider;
- Distributing directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information;
- Failing to maintain an adequate network of properly credentialed providers;
- Failing to comply with the provider reimbursement requirements of this contract;
- Failing to comply with the reporting requirements of this contract;
- A pattern of inappropriately denying payments for emergency-related services; or
- Violating the requirements of sections 1903(m) or 1932 of the Social Security Act, and any implementing regulations.

## **6.2 Corrective Action Plan**

At its option, the Department may require the MCO to submit to the Department or its designee a written plan (the “Corrective Action Plan”) to correct or resolve non-performance of this contract, as determined by the Department.

1. The Corrective Action Plan must provide:
  - A detailed explanation of the reasons for the MCO's non-performance;
  - The MCO's assessment or analysis of the cause, if applicable; and
  - A specific proposal to cure or resolve the non-performance.
2. The Department may require a Corrective Action Plan to provide:
  - Accelerated monitoring that includes more frequent or more extensive monitoring by the Department or its agent, including accelerated monitoring of any area in which the compliance is not fully met;
  - Additional, more detailed, financial, and/or programmatic reports to be submitted by the MCO; and
  - Additional and/or more detailed financial and/or programmatic audits or other reviews of the MCO.
3. The Corrective Action Plan must be submitted by the deadline set forth in the Department's request for a Corrective Action Plan. The Corrective Action Plan is subject to approval by the Department, which will not unreasonably be withheld.
4. The Department will notify the MCO in writing of its final disposition of the Department's concerns. If the Department accepts the MCO's proposed Corrective Action Plan, the Department may:
  - Condition such approval on completion of tasks in the order or priority that the Department may reasonably prescribe;
  - Disapprove portions of the MCO's proposed Corrective Action Plan; or
  - Require additional or different corrective action(s), not limited to the actions described in paragraph (2);
  - Notwithstanding the submission and acceptance of a Corrective Action Plan, MCO remains responsible for achieving all written performance criteria.
5. The Department's acceptance of a Corrective Action Plan under this Section will not:
  - Excuse the MCO's prior non-performance;
  - Relieve the MCO of its duty to comply with performance standards; or
  - Prohibit the Department from assessing additional contract remedies or pursuing other appropriate remedies for continued non-performance.

### **6.3 Conditions Endangering Performance**

At its option, the Department may provide the MCO with written notice of conditions endangering contract performance. Conditions that endanger performance include, but are not limited to, the following:

- Failing to substantially provide medically necessary 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, copays, or charges enrollees in excess of the premiums, copays, 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.

At any time 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 may 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 MCO fails to remedy the conditions contained in the notice, within ten working days or the time period specified in the notice, the Department may pursue other remedies under this contract.

#### **6.4 Failure to Meet Contract Requirements**

The MCO must comply with all requirements and performance standards set forth in this contract. The MCO agrees that failure to comply with all provisions of this contract may result in the assessment of remedies and/or termination of the contract, in whole or in part, in accordance with this Article.

MCO agrees and understands that the Department may pursue contractual remedies for non-performance under the contract. At any time and at its discretion, the Department may impose or pursue one or more remedies for each item of non-performance and will determine remedies on a case-by-case basis.

The Department is entitled to monetary damages in the form of actual, consequential, direct, indirect, special, and/or Liquidated Damages resulting from the MCO's non-performance under this contract. In some cases, the actual damage to the Department as a result of the MCO's failure to meet any aspect of the responsibilities of the contract and/or to meet specific performance standards set forth in the contract will be difficult or impossible to determine with precise accuracy. Therefore, in the event of non-performance under this contract, the Department will impose Liquidated Damages in writing against the MCO. In the event of non-performance the Department will assess Liquidated Damages against the MCO regardless of whether the non-performance is the fault of the MCO (including the MCO's subcontractors, agents and/or consultants), provided the Department has not materially caused or contributed to the non-performance.

The Liquidated Damages prescribed in this contract are not intended to be in the nature of a penalty, but are intended to be reasonable estimates of the Department's projected financial loss and damage resulting from the MCO's non-performance. Accordingly, in the event the MCO

fails to perform in accordance with the contract, the Department may assess Liquidated Damages as provided in this Section and in Exhibit H of this contract.

Any Liquidated Damages assessed by the Department will be due and payable within thirty (30) calendar days after the MCO's receipt of the notice of damages, regardless of any dispute in the amount or interpretation which led to the notice, or an appeal of the notice filed by the MCO. If MCO fails to pay assessed damages within 30 days, the amount of damages will be deducted against capitation payments due to the MCO or that become due at any time after assessment of the Liquidated Damages. The Department will make deductions until the full amount payable by the MCO is collected. All Liquidated Damages imposed pursuant to this contract, whether paid or due, must be paid by the MCO out of administrative costs and profits.

If at any time the Department determines the MCO has not met any aspect of the responsibilities of the contract and/or the specific performance standards due to mitigating circumstances, the Department reserves the right to waive all or part of the Liquidated Damages. All such waivers must be in writing, contain the reasons for the waiver, and be signed by the representative of the Department.

Neither the occurrence of an event constituting an alleged MCO non-performance of this contract nor the pending status of any claim for non-performance of contract is grounds for the suspension of performance, in whole or in part, by the MCO of any duty or obligation with respect to the performance of this contract.

## **6.5 Temporary Management**

The State may appoint temporary management as a remedy under the circumstances described in 42 CFR 438.706, if the State determines that the MCO has repeatedly failed to meet the substantive requirements in Sections 1903(m) or 1932 of the Social Security Act and that the continued operation of the MCO would be hazardous to enrollees. The Commissioner of the Offices of the Insurance Commissioner will be responsible for the imposition of such remedy as set forth in Section 33-25A-19 of the West Virginia HMO Act of 1977. If temporary management is imposed, the State will notify enrollees of their right to terminate enrollment in the MCO.

The State may terminate an MCO contract and enroll that entity's enrollees in other MCOs or provide their Medicaid benefits through other options included in the State Plan.

Nothing precludes the Department's right to appoint temporary management during the time in which the MCO is remedying the condition(s) or while an appeal requested by the MCO is pending. However, before any temporary management is appointed, the Department will notify, in writing, the MCO of the specific non-performance. Within ten working days of receipt of this written notification, the MCO will forward a plan to remedy this non-performance 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 non-performance in accordance with the plan, and will have 15 working days to do so. If the plan is not accepted, such reasons will 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 non-performance and will have 15 working days to do so.

## **6.6 Suspension of New Enrollment**

Whenever the Department determines non-performance by the MCO under this contract, the Department may suspend enrollment of new enrollees into the MCO 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 in accordance with Section 6.8. The suspension period may be for any length of time specified by the Department, or until the non-performance is remedied, or for an unspecified time period. The suspension period may extend up to the contract expiration date as provided under Article I. The Department may notify existing enrollees of the MCO non-performance and provide an opportunity to disenroll from the MCO and to re-enroll in another MCO.

## **6.7 Payment Suspension**

The Department may suspend portions of capitation payments from the MCO as a remedy for non-performance. Whenever the Department determines that the MCO has failed to provide one or more of the medically necessary covered contract services, the Department may suspend an estimated portion of the MCO's capitation payment in subsequent months. Such suspension amount will be equal to the amount of money the Department expected the MCO to pay for medically necessary covered contract services, plus any administrative costs involved. The MCO may not deny any medically necessary covered contract services in order to receive adjusted payment levels. The MCO will be given at least ten working days written notice prior to the suspension of any capitation payment in accordance with Section 6.8.

When it suspends payments under this section, the Department must submit to the MCO a list of the members for whom payment is being suspended, the nature of service(s) denied, and payments the Department must make to provide medically necessary covered contract services. When all payments have been made by the Department for the MCO medically necessary covered contract services, the Department will reconcile the estimated suspension against actual member payments.

The Department may suspend MCO payments in accordance with 42 CFR 455.23 in case of a credible allegation of fraud against the MCO.

## **6.8 Dispute Resolution**

This contract is not subject to arbitration. Any action concerning MCO non-performance under this contract will be decided in accordance with Article 6 of this contract by the Contracting Officer who will put his/her decision in writing and serve a copy on the MCO and Department as soon as administratively possible after the MCO non-performance was identified. The Contracting Officer's decision will 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.

As a response to an appeal, the Contracting Officer must 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 on the appeal within ten working days.



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

The administrative law judge, who will serve as an impartial fact finder, will issue a proposed decision to the MCO and to the Department within 60 days of the end of the hearing. The MCO and/or the Department will have ten working days after the mailing of the proposed decision to request a decision review. If such a request is made, the Secretary, Department of Health and Human Resources will, thereafter, issue a final decision. There must be no ex parte communications with the administrative law judge during pendency of the appeal. During any appeal process, the copies of all pleadings or other documents being filed in connection with the appeal must be delivered to the administrative law judge. The reasonable costs of an administrative appeal including costs of reporting and preparing a transcript will be paid by the party appealing. Such decision will be final except to the extent that the MCO appeals to the Circuit Court of West Virginia. The pendency of an appeal to the Secretary or the Circuit Court will not automatically stay any notice of termination which may be appealable.

Pending final determination of any dispute, the MCO must proceed diligently with the performance of this contract and in accordance with the Contracting Officer's direction.

The MCO's failure to follow the procedure set out above will be deemed a waiver of any claim which the MCO might have had.

The Department and the MCO agree that a State or Federal statute, rule, regulation, or Federal guideline will prevail over the provisions of this Section unless the statute, rule, regulation, or guidelines can be read together with this Section to give effect to both.

## **6.9 Termination For Default**

The Department may terminate performance of work under this contract in whole, or in part, whenever the MCO defaults in performance of this contract and fails to cure such default or make progress satisfactory to 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 will 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 will be deemed to have been issued as a termination for the convenience of the Department, and the rights and obligations of the parties will 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 will 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.

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 6.8, provide the MCO with written notice of the decision affirming or reversing the proposed termination of the contract, and the effective date of the termination, if applicable; and
- For an affirming decision, give enrollees of the MCO notice of the termination, and information regarding enrollees' options for receiving covered services following the termination, and the right to terminate enrollment in the MCO immediately without cause.

In the event of a termination for default, the MCO must be paid for those services which the MCO has provided.

The MCO may terminate performance of work under this contract in whole, or in part, with written notification to the Department, whenever the Department fails to make payment for services under this contract for 60 days and fails 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 are not exclusive and are in addition to any other rights and remedies provided by law or under this contract.

If the Department terminates the contract for default, the MCO will be responsible for all reasonable costs incurred by the Department, the State of West Virginia, or any of its administrative agencies to replace the MCO. These costs include, but are not limited to, the costs of procuring a substitute vendor and the cost of any claim or litigation that is reasonably attributable to the MCO's failure to perform any service in accordance with the terms of the contract.

#### **6.10 Termination for Convenience**

The 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 must 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 may not be permitted to reapply for participation in the Mountain Health Trust and West Virginia Health Bridge program for a period of not less than one year, or such time period determined by BMS, at the discretion of BMS.

### **6.11 Termination Due to Change in Law, Interpretation of Law, or Binding Court Decision**

Any change in Federal or State law, or any interpretation of law by the United States Department of Health and Human Services or by a court whose decisions constitute binding precedent in West Virginia, which significantly alters the MCO's required activities or any change in the availability of funds, will be viewed as binding and will warrant good faith renegotiation of the provisions of the contract that are thus affected. If such renegotiation proves unsuccessful, the contract may be terminated on written notice of either party to the other party at least 30 days prior to termination.

### **6.12 Termination for Managed Care Organization Bankruptcy**

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

### **6.13 Termination for Unavailability of Funds**

The 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 will have the right not to continue the contract if the new contract terms are deemed to be insufficient, notwithstanding any other provision of this contract. The MCO will have a minimum of 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, hereof at the end of the affected current fiscal period without further charge or penalty. The Department is obligated to pay all charges incurred through the end of the then fiscal year at which time this contract will terminate. The Department must 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 may accrue to the Department in the event this provision is exercised.

## **6.14 Termination Obligations of Contracting Parties**

Upon contract termination, the MCO must 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 may no longer accept new enrollees. The MCO will remain responsible for providing services, including coverage of inpatient services, through the effective date of the contract termination, to individuals enrolled with the MCO on or before the date of notification to BMS and to newborns born to enrolled mothers during the remaining contract period. The MCO must provide BMS with the names, PCP assignments, and primary diagnosis of all enrollees with care needs that require WVDHHS pre-authorization, those currently receiving case management, and those with known future service needs (e.g. scheduled ambulatory surgery, pregnancy) by such date as determined by BMS, with weekly updates thereafter. The MCO must provide BMS with the names and treatment plans of enrollees with such plans.

Upon contract termination, the MCO must provide BMS with all required reports and data through the end of the contract period as described in this contract. This requirement includes encounter data, which must be submitted no later than 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 will be responsible for notifying all enrollees of the date of termination and process by which the enrollees will continue to receive services; and
- The MCO will be responsible for all reasonable expenses related to said notification.

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

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

## **6.15 Waiver of Default or Breach**

Waiver of any default will not be deemed to be a waiver of any subsequent default. Waiver of breach of any provision of the contract will not be deemed to be a waiver of any other or subsequent breach and will not be construed to be a modification of the terms of the contract unless stated to be such in writing, signed by an authorized representative of the Department and the MCO, and attached to the original contract.

## **6.16 Severability**

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

## **6.17 Modification of the Contract in the Event of Remedies**

The Department may propose a modification of this contract in response to the imposition of a remedy under this Article. Any modifications must be reasonable, limited to the matters causing the exercise of a remedy and must be in writing.

# **7. OTHER REQUIREMENTS**

## **7.1 Inspection of Facilities**

The MCO must 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 must provide reasonable facilities and assistance for the safety and convenience of the persons performing those duties (e.g., assistance from MCO staff to retrieve and/or copy materials). BMS and its authorized agents will request access in writing except in case of suspected fraud 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 must, upon request, provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the State or Federal representatives conducting the audit or inspection effort.

All inspections or audits will be conducted in a manner that will not unduly interfere with the performance of the MCO's or any subcontractors activities. The MCO will be given ten working days to respond to any findings of an audit before BMS will finalize its findings. All information so obtained will be accorded confidential treatment as provided under applicable law.

## **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 must comply with the record retention requirements of Title 45, Sections 74.21 through 74.23 (45 CFR 74.21 through 74.23).

Such records, with the exception of medical records and 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 must 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 must 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, must 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 agrees 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 will 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 must 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 must properly reflect all revenues and all costs of whatever nature for which reimbursement is claimed under the provisions of the contract. All such documents must be made available to BMS at its request, and must 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, must 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 must 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 enter into a subcontract agreement to fulfill the requirements of this contract subject to the Department review and approval. The Department 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 the Department review and approval.

The Department reserves the right to require the corrective action plan or replacement of any subcontractor found by the Department to be unable to meet the requirements of this contract. The Department reserves the right to disallow a proposed subcontracting arrangement if the proposed subcontractor has been formally restricted from participating in a federal entitlement program (i.e., Medicare, Medicaid).

The MCO must submit a report listing each subcontract, subcontractor name, subcontract effective dates and functions by July 1st of every year to the Department.

The requirements of this Section do not apply to subcontracts entered into for the provision of any of the following: utilities (e.g., water, electricity, telephone, Internet), mail/shipping, office space, or computer hardware.

The MCO's subcontract agreement must require a written notice of intent to be furnished by the MCO or its subcontractor in case of the subcontract termination for any reason. A written notice of intent must be given within the following timeframes:

- 90 days prior to the termination date of a subcontract for systems operations or reporting;
- 30 days prior to the termination date of a subcontract for administrative services; and

- 30 days prior to the termination date of any other subcontract.

A written notice of intent is not required in case of a serious breach of a subcontract. The MCO must provide the Department with a written notification no later than three business days if a serious breach of a subcontract occurs.

The MCO must provide the Department with a written notification no later than five business days after receiving a written notice from a subcontractor or giving a notice to subcontractor of the intent to terminate a subcontract for any reason.

Subcontracts must comply with the requirements of 42 CFR 434.6 and 42 CFR 438.230. All subcontracts must be in writing, and the MCO must provide the Department the right to examine the subcontract and all subcontractor records relating to this contract. The subcontract agreement must include any applicable requirements of this contract that are appropriate to the services being provided, and must assure that all delegated duties under this subcontract are performed to the same extent as if such were performed by the MCO.

Subcontracts must not terminate legal liability of the MCO under this contract including but not limited to Section 6 of this contract.

Subcontracts must provide that all information that is obtained through performance under this contract, including, but not limited to, information relating to applicants or recipients of the Department programs, is confidential to the extent that confidential treatment is provided under state and federal law, rules, and regulations.

The MCO must maintain and keep current a subcontractor monitoring plan for each of its subcontractors listed above. The MCO must provide a copy of its subcontractor monitoring plan within 10 business days of the Department written request.

The MCO may not modify, convey, sell, transfer, assign, delegate, or otherwise dispose of the contract or any portion thereof or of any right, title, or interest therein without the prior written consent of the Department. This provision includes reassignment of the contract due to change in ownership of the MCO. The Department in its discretion may grant such written approval of an assignment, transfer, delegation or subcontract, provided, however, that this paragraph may not be construed to grant the MCO any right to such approval. This paragraph may not be construed as restricting the MCO from entering into contracts with participating providers to provide health care services to plan enrollees.

The MCO is solely responsible for the fulfillment of this contract with the Department. 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. The Department 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 must 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**

The MCO, as a “disclosing entity,” must supply BMS with full and complete information of each person (individual or corporation) with an ownership or control interest in the MCO or the MCO’s subcontractor in which the MCO has direct or indirect ownership of five percent or more, in accordance with 42 CFR 455.104. This disclosure must include for each person:

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

The disclosures must be submitted at the time of contract execution, contract renewal, or contract extension, within 35 days after any change in ownership of the MCO, and within 35 days of BMS request. The MCO must also submit to BMS a copy of any information it submits to the Department of Insurance regarding disclosure of ownership or control interest.

### ***Prohibited Affiliations with Individuals Debarred by Federal Agencies***

The MCO may not have a director, officer, principal, partner, agent, managing employee, or other person with ownership or control interest of five percent or more in the MCO and who:

- Has been convicted of a criminal offense as described in sections 1128(a) and 1128(b) (1), (2), or (3), of the Social Security Act;
- Has had civil money penalties or assessments imposed under section 1128A of the Social Security Act; or

- Has been excluded, suspended, or debarred from participation in Medicare or any state health care programs.

The MCO must submit information as described above, for any person who was formerly described as a director, officer, principal, partner, agent, managing employee, or other person with ownership or control interest of five percent or more in the MCO, but is no longer so described because of a transfer of ownership or control interest to an immediate family member or a member of the person's household, in anticipation of or following a conviction, assessment of a civil monetary penalty, or imposition of an exclusion.

The MCO is prohibited from having a consulting or any other agreement with an excluded, debarred or suspended person for the provision of items or services that are significant and material to the MCO's contractual obligation with the State.

The MCO must immediately inform BMS of any circumstances that are grounds for its exclusion, or the exclusion of its contracted providers, from participation in the Medicaid program, in accordance with 42 CFR 1001.1001 and 42 CFR 1001.1051.

At the time of contract and contract renewal or upon written request by BMS, the MCO must submit information on any person who is a director, officer, principal, partner, agent, managing employee, or other person with ownership or control interest of five percent or more in the MCO and who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs, as required in 42 CFR 455.106.

If BMS finds that the MCO is not in compliance with this provision, BMS: (1) will notify the Secretary of the Department of Health and Human Services of such noncompliance; (2) may discontinue the existing agreement with the MCO if so directed by the Secretary (in consultation with the Inspector General of the Department of Health and Human Services); and (3) will not renew or otherwise extend the duration of the existing agreement with the MCO unless the Secretary (in consultation with the Inspector General) provides to BMS and to Congress a written statement describing compelling reasons that exist for doing so.

#### ***Business Transactions of Medicaid Providers***

Federal regulations contained in 42 CFR 455.105 require the MCO to disclose the following information related to business transactions within 35 days of request of the Secretary of DHHS or BMS: full and complete information about (1) the ownership of any subcontractor with whom the MCO has had business transactions totaling more than \$25,000 during the previous 12-month period and (2) any significant business transactions between the MCO and any wholly owned supplier, or between the MCO and any subcontractor, during the previous five years.

## 8. SIGNATURES

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

### **West Virginia Department of Health and Human Resources**

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

### **Managed Care Organization**

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

## ARTICLE III: STATEMENT OF WORK

### 1. COVERED SERVICES

#### 1.1 Covered MCO Services

The MCO must provide to enrollees enrolled under this contract, directly or through arrangements with others, all of the covered services described in Contract 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 SFY16 Mountain Health Trust and West Virginia Health Bridge Payment Methodology and Capitation Rates) contains a listing of the current capitation rates.

The MCO must provide covered services to Medicaid enrollees under this contract in the same manner as those services are provided to other enrollees of the MCO, although delivery sites, covered services, and provider payment levels may vary. The MCO must guarantee that the locations of facilities and practitioners providing health care services to enrollees are sufficient in terms of geographic convenience to low-income areas, handicapped accessibility, and proximity 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 by the Department outside of the MCO capitation system).

#### *Perform the Screenings*

MCOs must provide screenings (periodic comprehensive child health assessments) according to the West Virginia Periodicity Schedule to all enrollees eligible to receive them. The Periodicity Schedule is maintained by the Office of Maternal and Child Health within the Bureau for Public Health at the Department for Health and Human Resources, and corresponds to the American Academy of Pediatrics' Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents.

Covered screening services are regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. At a minimum, these screenings must include, but are not limited to:

1. A comprehensive health and developmental history (including assessment of both physical and mental health development); ;
2. An unclothed physical exam;
3. Laboratory tests (including blood lead screening appropriate for age and risk factors);
4. Vision testing;
5. Appropriate immunizations, in accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices;
6. Hearing testing;
7. Dental services (furnished by direct referral to a dentist for children beginning beginning 6 months after the first tooth erupts or by 12 months of age );
8. Behavioral health screening; and
9. Health education (including anticipatory guidance).

MCOs must also provide interperiodic screenings, which are any encounters with a health professional practicing within the scope of his or her practice and who provides medically necessary health care, diagnosis, or treatment to determine the existence of a suspected illness or condition, or a change or complication to a pre-existing condition. The interperiodic screen is used to determine if there is a problem that was not evident at the time of the regularly scheduled screen, but needs to be addressed before the next scheduled screen.

### *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; 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 such other necessary health care and all follow-up diagnostic and treatment services deemed medically necessary to ameliorate or correct defects and physical and mental illnesses and conditions discovered by the screening services. Medically necessary services must be contained within the categories of mandatory and optional services listed in Section 1905(a) of the Social Security Act, whether or not such services are covered under the State Plan.

Per 42 CFR 441.61(a), in the event a child needs a treatment that is not coverable under the categories listed in Section 1905(a) of the Social Security Act, the MCO must provide referral assistance that includes giving the family or beneficiary the names, addresses, and telephone numbers of providers who have expressed a willingness to furnish uncovered services at little or no expense to the family.

The MCO is responsible for determining if services are medically necessary. The determination of whether a service is medically necessary for an individual child must be made on a case-by-case basis, taking into account the particular needs of the child. Because medical necessity decisions are individualized, flat limits or hard limits based on a monetary cap or budgetary constraints are not consistent with EPSDT requirements

### *Track Referrals and Treatments*

MCOs must establish a tracking system that provides up-to-date information on compliance with EPSDT service provision requirements including a Periodicity Schedule of preventive services and standards of care in the following areas:

1. Initial visit for newborns. The initial EPSDT screen must be the newborn physical exam in the hospital, birthing center, at home or other setting. Based in part upon the results of the birth score procedure conducted through the hospital or birthing center under the auspices of the Bureau for Public Health, the periodicity of preventive pediatric visits must follow schedule 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 West Virginia's Periodicity Schedule up to age 21.
3. Diagnosis and/or treatment, or other referral in accordance with EPSDT screen results. The MCO must employ processes to ensure timely initiation of treatment, if required, generally within an outer limit of 6 months after the screening services.

#### *Report the Results*

The Department is responsible for ensuring that the MCO fulfills its contractual responsibilities to inform all families of the services available under EPSDT and how to access them.

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

#### **Emergency Care**

MCO policy and procedures, covered Medicaid services, claims adjudication methodology, and reimbursement performance for emergency care services must comply with all applicable state and federal laws, rules, and regulations, including 42 CFR 438.114, whether the provider is in the MCO's network or out-of-network. The MCO must cover and pay for all medical, behavioral, pharmacy, and dental 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.<sup>2</sup> The terms "emergency care," "urgent care," "emergency medical conditions," and "emergency dental condition" are defined in Article II of this contract. Reimbursement for emergency services provided 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 non-participating 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.

If the enrollee is participating in a chronic care health home, the health home must be notified of any use of emergency services and be notified of any inpatient admission or discharge of a health home member that the MCO learns of through its inpatient admission initial authorization and concurrent review processes within 24 hours.

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.

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<sup>2</sup> 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.



The MCO may not deny payment for treatment obtained when an enrollee had an emergency medical or dental condition in which the absence of immediate medical attention would have placed the health of the individual, or in the case of a pregnant women, the woman or her unborn child, in serious jeopardy; resulted in serious impairment to bodily functions; or resulted in 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, except for the applicable non-emergency copays paid by the member.

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

A medical screening examination needed to diagnose an enrollee's emergency medical condition must be provided in a hospital-based emergency department that meets the requirements of the Emergency Medical Treatment and Active Labor Act (EMTALA) (42 CFR 489.20, 489.24 and 438.114(b)&(c)). The MCO must pay for the member's emergency medical screening examination, as required by 42 U.S.C. 1395dd. The MCO must reimburse for both the physician's services and the hospital's emergency services, including the emergency room and its ancillary services, so long as the "prudent layperson" standard (as defined above) has been met.

### ***Post-Stabilization Care***

The MCO must cover and pay for post-stabilization care services in the amount, duration, and scope necessary to comply with 42 CFR 438.114(b)&(e) and 42 CFR 422.113.

These regulations state that the MCO must make timely and reasonable payment to or on behalf of the plan enrollee for the following services obtained from a provider or supplier whether or not that provider or supplier contracts with the MCO to provide services covered by the MCO. Post-stabilization care services are covered services 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 all Medicaid covered family planning services without prior authorization through any Medicaid provider, who will bill the MCO and be paid on a fee-for-service basis.<sup>3</sup>

The MCO must give each enrollee, including adolescents, the opportunity to use his/her own primary care provider or go to any family planning center for family planning services without requiring a referral. The MCO must make a reasonable effort to subcontract with all local family planning clinics and providers, including those funded by Title X of the Public Health Services Act, and must reimburse providers for all family planning services regardless of whether they are rendered by a participating or non-participating provider. Unless otherwise negotiated, the MCO must reimburse providers of family planning services at the Medicaid rate. The MCO may, however, at its discretion, impose a withhold on a contracted primary care provider for such family planning services. The MCO may require family planning providers to submit claims or reports in specified formats before reimbursing services.

MCOs must provide their Medicaid enrollees with sufficient information to allow them to make an informed choice including: the types of family planning services available, their right to access these services in a timely and confidential manner, and their freedom to choose a qualified family planning provider both within and outside the MCO's network of providers. In addition, MCOs must ensure that network procedures for accessing family planning services are convenient and easily comprehensible to members. MCOs must also educate members regarding the positive impact of coordinated care on their health outcomes, so members will prefer to access in-network services or, if they should decide to see out-of-network providers, they will agree to the exchange of medical information between providers for better coordination of care.

In addition, MCOs are required to provide timely reimbursement for out-of-network family planning and related STD services consistent with services covered in their contracts. The reimbursement must be provided at least at the applicable West Virginia Medicaid fee-for-service rate appropriate to the provider type (current family planning services fee schedule available from BMS).

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<sup>3</sup> 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.

The MCO, its staff, contracted providers and its contractors that are providing cost, quality, or medical appropriateness reviews or coordination of benefits or subrogation must keep family planning information and records confidential in favor of the individual patient, even if the patient is a minor. The MCO, its staff, contracted providers and its contractors that are providing cost, quality, or medical appropriateness reviews, or coordination of benefits or subrogation must also keep family planning information and records received from non-participating providers confidential in favor of the individual patient even if the patient is a minor. Maternity services, hysterectomies, and pregnancy terminations are not considered family planning services.

#### *Conditions for Out-of-Network Reimbursement of Family Planning Services*

All MCOs must reimburse out-of-network providers for family planning services rendered to enrollees. Unless otherwise negotiated, the MCO must reimburse providers of family planning services at the Medicaid rate. The following are the conditions under which family planning providers will be reimbursed for family planning services provided to Medicaid enrollees:

1. The family planning provider must be qualified to provide family planning services based on licensed scope of practice;
2. The family planning provider must submit claims on appropriate MCO-specific billing forms; and
3. The family planning provider must provide medical records sufficient to allow the MCO to meet its case management responsibilities. If an enrollee refuses the release of medical information, the out-of-network provider must submit documentation of such refusal.

In order to avoid duplication of services, promote continuity of care, and achieve the optimum clinical outcome for Medicaid enrollees, MCOs 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 must refer the enrollee back to the MCO.

Non-participating providers are responsible for keeping family planning information confidential in favor of the individual patient even if the patient is a minor. The MCO is not responsible for the confidentiality of medical records maintained by non-participating providers.

#### **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.

Those Medicaid-covered services that are excluded from the capitation rates (e.g., non-emergency transportation) have particular coordination requirements for MCOs, which are outlined below.

#### ***Non-emergency Transportation***

Non-ambulance medical transportation to and from Medicaid covered scheduled medical appointments is covered by the non-emergency medical transportation (NEMT) broker Medicaid program. This includes transportation via multi-passenger van services and common carriers such as public railways, buses, cabs, and airlines, and private vehicle transportation by individuals. The NEMT broker must approve multi-passenger van services and transportation by common carriers. The MCO must inform enrollees of how to access non-emergency transportation as appropriate.

#### ***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 MCO. Hemophilia-related clotting factor drugs will be covered by the fee-for-service Medicaid program. Drugs and supplies dispensed by a physician acquired by the physician at no cost are not covered by Medicaid.

### **1.4 Non-covered Services**

MCOs are not permitted to provide Medicaid excluded services that include, but are not limited to, the following:

1. All non-medically necessary services.
2. Sterilization of a mentally incompetent or institutionalized individual.
3. Except in an emergency, inpatient hospital tests that are not ordered by the attending physician or other licensed practitioner, acting within the scope of practices, who is responsible for the diagnosis or treatment of a particular patient's condition.
4. All organ transplants, except for those specified in Exhibit A.
5. Treatments for infertility<sup>4</sup> and for the reversal of sterilization.
6. Sex transformation procedures and hormone therapy associated with sex transformation procedures.

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<sup>4</sup> Infertility services are excluded per West Virginia State law, section 33-25A-4(2)(b).

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 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.<sup>5</sup>

MCOs and their participating providers may not bill or collect any payment from Medicaid enrollees for care that was determined not to be medically necessary. Anyone who knowingly and willfully charges for any service provided to a patient under a State Plan approved under Title XIX or under a MCO contract under 1903(m) of the Social Security Act, money or other consideration at a rate in excess of the rates established by BMS or contract will be guilty of a felony and upon conviction will be fined no more than \$25,000 or imprisoned for no more than five years, or both.

### **1.6 Requirements Pertaining to Medicaid Managed Care Programs**

The MCO must follow the benefit packages and policies of Medicaid managed care programs as required by this Contract and Contract Exhibits. The MCO should refer to the fee-for-service Medicaid provider manuals available on the WV DHHR website for an explanation of service limitations under the Mountain Health Trust or West Virginia Health Bridge.

#### ***PCP Responsibilities***

PCPs will be the MCO enrollee's initial and most important contact with the Medicaid MCO. The PCPs' responsibilities are outlined in Article III, Section 2.2 of the contract.

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

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<sup>5</sup> 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.

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.”

## **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), dental, and specialty care providers in sufficient numbers to make available all covered services as required by the availability and access standards of the contract. The MCO must 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 must consider the following:

- Anticipated Medicaid enrollment;
- Expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented by the MCO;
- Numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services;
- Numbers of network providers who are not accepting new Medicaid patients; and
- Geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities.

### **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, pharmacies 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 state that:

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

- 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
- MCOs should encourage SSI members to schedule an appointment with a PCP or specialist who manages the member's care within 45 days of initial enrollment. If requested by the member or provider, the MCO should schedule or facilitate an appointment with the member's PCP.

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***

The MCO must implement written policies and procedures for selection and retention of affiliated providers. If such functions are delegated, credentialing and recredentialing policies and procedures must meet the requirements of this section. In contracting with its providers, the MCO must abide by all applicable federal regulations including but not limited to W. Va. C.S.R. §114-53-6 and 42 CFR 438.610 and 42 CFR 455, Subpart B.

For physicians and other licensed health care professionals, including 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 denying, 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 comply with W. Va. C.S.R. §114-53-6 and 42 CFR 455, Subpart B and at a minimum 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;
- Felony convictions as required by W. Va. C.S.R. §114-53-6.3 and other criminal convictions as required by 42 CFR 455.106 ;
- History of loss or limitation of privileges or disciplinary activity;
- History of debarment, suspension or exclusion from any Federal or State healthcare programs; and
- An attestation to correctness/completeness of the application.

During the initial credentialing process, the MCO must verify:

- The identity and the exclusion status of provider and any person with an ownership or control interest or who is an agent or managing employee of the provider through checks of Federal databases as described in 42 CFR 455.436;
- The provider holds a current valid license to practice;
- Valid 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 provider as the primary admitting facility (this requirement may be waived for practices which do not have or do not need access to hospitals);
- The provider holds current, adequate malpractice insurance with minimum coverage requirements of \$1 million per individual episode and \$1 million in the aggregate;
- Any revocation or suspension of a state license or DEA/BNDD number;
- Any curtailment or suspension of medical staff privileges (other than for incomplete records);
- Any censure by the State or County Medical Association; and
- Any enrollee complaints.

In addition, the MCO must request information on the provider from the National Practitioner Data Bank and appropriate state licensing boards such as the Board of Medicine, Chiropractic Board, Osteopathic Board and/or Dental Board.

The MCO must perform monthly federal databases checks as required by 42 CFR 455.436. The MCO must examine exclusion and debarment status for all providers, entities, persons with ownership and control interest, agents, principals, partners, directors, and managing employees using the HHS-OIG's List of Excluded Individuals/Entities (LEIE) and the Excluded Parties List System (EPLS). All providers must be matched against the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), and other appropriate databases to confirm provider identity upon contracting. The MCO must check the LEIE and EPLS no less frequently than monthly. The EPLS database can be found at the System for Award Management (SAM) website. The LEIE database can be found at the HHS-OIG website.

Additional credentialing and recredentialing criteria for PCPs, obstetricians/gynecologists and other high-volume specialists must include a visit to the provider's office, documenting a structured review of the site and medical record keeping practices to ensure conformance with the MCO standards.

Additional credentialing and recredentialing criteria for dental providers must include: Anesthesia permit and/or certificate from the West Virginia Board of Dental Examiners for those dental providers who induce central nervous system anesthesia.

Additional credentialing and recredentialing criteria for behavioral health care providers and agencies must include:

- The MCO must verify that a Comprehensive Behavioral Health Center or a Licensed Behavioral Health Center holds a valid license through the West Virginia Office of Health Facility Licensure and Certification;
- The MCO must verify that an independent psychologist or an independent practicing licensed social worker holds current license with their professional boards; and
- The MCOs must verify the MCO physician is approved to provide Suboxone® treatment by the Department. A licensed MCO physician who intends to provide Suboxone® treatment must meet the following requirements:
  - physician must qualify for a waiver under the Drug Addiction Treatment ACT (DATA);
  - physician must have an assigned DEA (X) number and complete the training regarding Suboxone® treatment guidelines;
  - physician must notify the Center for Substance Abuse Treatment of the intention to treat addiction patients; and
  - at no time can a Nurse Practitioner or a Physician's Assistant be qualified to prescribe Suboxone®.

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 may not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. This law may not be construed to prohibit the MCO from including providers only to the extent necessary to meet the needs of the MCO's enrollees from using different reimbursement amounts for different specialties or for different practitioners in the same specialty, or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the MCO. If the MCO declines to include providers in its network, the MCO must give the affected providers written notice of the reason for its decision.

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. If the MCO requests a service area expansion, it must

demonstrate its capability to serve additional enrollees in the service area specified in the request. A service area expansion will be effective the first of the month after BMS confirms that additional capacity exists in the expanded service area.

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

### ***Network Changes***

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

In cases of PCP withdrawals, the MCO must also provide enrollees with at least 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 must 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.

### ***MCO Provider Contract Requirements***

The MCO's provider contracts and addenda to provider contracts must abide by all federal regulations and must be consistent with the requirements of this statement of work and at a minimum must include the following provisions:

1. Enrollees will be held harmless for the costs of all Medicaid-covered services provided except for applicable cost-sharing obligations. The contract must state that the providers must inform enrollees of the costs for non-covered services prior to rendering such services. The provider contract must state that the MCO's enrollees may not be held liable for the MCO's debts in the event of the MCO's insolvency;
2. Physicians will maintain adequate malpractice insurance with minimum coverage requirements of \$1 million per individual episode and \$1 million in the aggregate;
3. Reimbursement terms. The contract must provide a complete description of the payment method or payment amounts applicable to a provider. The MCO provider contract or provider manual must explain to providers how to submit a clean claim including a complete listing of all required information, including claims coding and processing guidelines for the applicable provider type. The MCO must pay in-network providers within 30 days of clean claims receipt. The MCO provider must understand and agree that BMS is not liable or responsible for payment for covered services rendered pursuant to the MCO provider contract;

4. Clear definition of each party's termination options;
5. Requirements for provider disclosure of ownership and control, in accordance with 42 CFR 455.104. The MCO provider contracts must include language defining ownership per 42 CFR 455.101. The MCO provider contracts or disclosure forms must request the provider to disclose information on ownership and control, and information on interlocking relationships per 42 CFR 104 b (3). A provider that is a business entity, corporation, or a partnership must disclose the name, DOB, SSN, and address of each person who is provider's director, officer, principal, partner, agent, managing employee, or other person with ownership or control interest of five percent or more in the provider or in the provider's subcontractor. The address for corporate entities must include as applicable: primary business address, every business location, P.O. Box address, and tax ID. Contracts or disclosure forms must solicit information on interrelationships of persons disclosed per 42 CFR 455.104 (b). MCO contracts or disclosure forms must request tax ID of any provider's subcontractor in which the provider (if entity) has a 5 percent or more interest. The MCO provider contracts must request the name of each entity in which the provider's persons with ownership and control interest have an ownership or control interest. The provider must agree to keep information current at all times by informing the MCO in writing within 35 days of any ownership and control changes to the information contained in its application;
6. Requirements for provider disclosure of significant business transactions, in accordance with 42 CFR 455.105. MCO provider contracts must include language specifying that the contracted provider is required to disclose the following information related to business transactions within 35 days of request of the Secretary of DHHS or BMS: full and complete information about (1) the ownership of any subcontractor with whom the provider has had business transactions totaling more than \$25,000 during the previous 12-month period and (2) any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the previous five years;
7. Requirements for provider disclosure of health-care related criminal convictions, in accordance with 42 CFR 455.106. The provider contracts or disclosure forms must request the provider, provider's director, officer, principal, partner, agent, managing employee, or other person with ownership or control interest of five percent or more in the provider to disclose information on criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on request. The contracts must require a provider to notify the MCO immediately of the time the provider receives notice of such conviction. The MCO must include the definition of "Convicted" per 42 CFR 1001.2 in the contract or disclosure form;
8. Requirements for providers to report to the MCO provider-preventable conditions associated with claims;
9. Certification that the provider, provider's director, officer, principal, partner, managing employee, or other person with ownership or control interest of five percent or more in the provider have not been excluded, suspended, debarred, revoked, or any other synonymous action from participation in any program under Title XVIII (Medicare), Title XIX (Medicaid), or under the provisions of Executive Order 12549, relating to

federal agreement. Certification that persons listed above have also not been excluded, suspended, debarred, revoked, or any other synonymous action from participation in any other state or federal health-care program. Requirement for a provider to notify the MCO immediately of the time it receives notice that any action is being taken against a provider or any person above as defined under the provisions of Section 1128(A) or (B) of the Social Security Act (42 USC §1320a-7), which could result in exclusion from the Medicaid program. A provider must agree to fully comply at all times with the requirements of 45 CFR Part 76, relating to eligibility for federal agreements and grants;

10. Requirements for access to provider records. The provider contracts must include a provision requiring MCO providers to provide to BMS: 1. all information required under the MCO's managed care contract with BMS, including but not limited to the reporting requirements and other information related to the network providers' performance of its obligations under the MCO provider contracts; and 2. any information in its possession sufficient to permit BMS to comply with the federal Balanced Budget Act of 1997 or other federal or state laws, rules, and regulations. MCO provider contracts must include a provision explaining that, if the network provider places required records in another legal entity's records, such as a hospital, the network provider is responsible for obtaining a copy of these records for use by the above named entities or their representative;
11. Requirement for providers to comply with 42 CFR 438.104. The contract must prohibit providers from engaging in direct marketing to enrollees that is designed to increase enrollment in a particular MCO. The prohibition should not constrain providers from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance;
12. Requirement to comply with Section 6032 of the Deficit Reduction Act of 2005, if the network provider receives annual Medicaid payments of at least \$5 million (cumulative, from all sources). A provider must: 1. Establish written policies for all employees, managers, officers, contractors, subcontractors, and agents of the network provider. The policies must provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A). 2. Include as part of such written policies detailed provisions regarding the network provider's policies and procedures for detecting and preventing Fraud, Waste, and Abuse. 3. Include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68)(A), the rights of employees to be protected as whistleblowers, and the provider's policies and procedures for detecting and preventing Fraud, Waste, and Abuse;
13. Requirement to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191), and the Health Information Technology for Economic and Clinical Health Act (HITECH Act) at 42 U.S.C. 17931 et.seq. The contract must explain that the provider must treat all information that is obtained through the performance of the services included in the provider contract as confidential information to the extent that confidential treatment is provided under state and federal laws, rules, and regulations. This includes, but is not limited to, information relating to applicants or recipients of BMS programs.

14. Requirement that provider may not interfere with or place any liens upon the State's right or the MCO's right, acting as the State's agent, to recovery from third party resources;
15. Requirement for provider to comply with 42 CFR 422.128 and West Virginia Health Care Decisions Act relating to advance directives;
16. Description of the MCO's provider complaint and appeal processes. The processes must comply with the requirements of this Contract, 42 CFR 438.414, and must be the same for all providers;
17. The provider contract must prohibit providers from collecting copays for missed appointments;
18. The provider contract must require emergency care providers to educate the member of the amount of his or her copay for non-emergency services provided in the emergency department prior to providing non-emergency services. The emergency services provider must be required to provide a member with the name and location of an available and accessible alternative non-emergency services provider.

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:

- Maintaining continuity of each enrollee's health care by serving as the enrollee's primary care provider;
- Providing 24-hour, seven-day-a-week access;
- Making referrals for specialty care and other medically necessary services, both in-network and out-of-network, consistent with the MCO's utilization management policies;
- Maintaining a current medical record for the enrollee, including documentation of all services provided to the enrollee by the PCP, as well as any specialty or referral services;
- Adhering to the EPSDT Periodicity Schedule for enrollees under age twenty-one (21); and
- Following MCO-established procedures for coordination of in-network and out-of-network services for Medicaid enrollees.

Although PCPs must be given responsibility for the above activities, the MCO must also retain responsibility for monitoring PCP actions to ensure they comply with MCO and West Virginia Medicaid managed care program policies.

Additionally, the MCO must communicate with PCPs about the delivery of primary behavioral health services within their scope of practice, as well as the appropriate circumstances for making referrals to behavioral health providers. MCOs may provide this information through its provider manual, continuing education agendas, informal visits by provider representatives, or any other means. The MCO must ensure that PCPs are successfully identifying and referring patients to a behavioral health provider and provide education to PCPs who do not have training in this area.

#### ***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 2,000 Medicaid members. The 2,000 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 2,000 Medicaid members. MCOs must reduce the caseload for PCPs with panels above 2,000 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.<sup>6</sup> MCOs must contract with these providers to the extent practical.

## **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.<sup>7</sup> 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

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<sup>6</sup> 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.

<sup>7</sup> 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.

sign exclusive contracts with any publicly supported providers that prevent the providers from signing contracts with other MCOs. Upon BMS notification to the MCO of any changes to the FQHC/RHC reimbursement rates, the MCOs must update payment rates to FQHC/RHC effective the date of notification by the Department. 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.

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 must 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 MCO must 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. 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, thus enabling children with special health care needs to receive a patient/family-centered medical home approach to comprehensive, coordinated services and supports.

The MCO is encouraged, but not required, to contract with CSHCN providers. However, if the MCO does not contract with CSHCN providers, the MCO must provide the same level and types of services as those currently available through the CSHCN program. This includes access to multidisciplinary care. The CSHCN eligibility criteria and services are available from BMS. BMS will monitor compliance with this requirement; if the MCO fails to satisfy these requirements, it will be required to reimburse the traditional CSHCN providers at the Medicaid fee rate.

### **2.5 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 2,000 Medicaid enrollees, the PCP may admit additional, non-Medicaid patients.

## **2.6 Provider Services**

### ***Provider Services Department***

The MCO must maintain a Provider Services Department and operate a toll-free provider phone line for at least 8 hours a day during regular business hours. The MCO Provider Services Department is responsible for the following, but not limited to:

1. Assisting providers with questions concerning enrollee eligibility status;
2. Assisting providers with plan prior authorization and referral procedures;
3. Assisting providers with claims payment procedures;
4. Handling provider complaints;
5. Providing and encouraging training to providers to promote sensitivity to the special needs of this population;
6. Educating providers in regards to Mountain Health Trust and West Virginia Health Bridge; and
7. Educating providers in regards to the MCO's written policies on the False Claims Act, including policies and procedures for detecting and preventing waste, fraud, and abuse. This requirement is pursuant to the Deficit Reduction Act of 2005, Section 6032.

The MCO must ensure that after regular business hours the line is answered by an automated system with the capability to provide callers with operating hours, information and instructions on how to verify enrollment for a member with an Urgent Condition or an Emergency Medical Condition.

The MCO must ensure that the toll-free provider phone line meets the following minimum performance requirements:

1. Eighty three percent (83%) of calls are answered live within thirty (30) seconds during operating hours. Time measured begins when the provider is placed in the call queue to wait to speak to a Provider Services representative;
2. The call abandonment rate does not exceed five (5) percent of total calls for the reporting period.

If the MCO's subcontractor operates a separate call center, the subcontractor's call center must at a minimum meet the provider phone line performance standards set forth in this Section.

### ***Provider Manual***

The MCO must develop, distribute and maintain a provider manual. The MCO must submit a copy of the provider manual to BMS by July 1 of each contract year. In addition, the MCO must document the approval of the provider manual by the MCO Administrator and Medical Director and must maintain documentation that verifies that the provider manual is reviewed at least annually. The MCO must ensure that each provider (individual or group which submits claim and encounter data) is issued a printed or electronic copy of the provider manual during the contracting process with the MCO. The MCO must provide a copy of the provider manual

to a provider upon request . When there are program or service site changes, notification will be provided to the affected providers at least thirty calendar days before the intended effective date of the change. The MCO must publish and keep current its provider manual on the MCO website.

### ***Provider Information Systems Support***

The MCO must make its hardware, software, and communications capable of accommodating individual provider information systems. Such accommodations may not be in violation any requirements promulgated pursuant to Health Insurance Portability and Accountability Act of 1996, P.L. 104-191 (August 21, 1996), as amended or modified, Health Information Technology for Economic and Clinical Health Act (HITECH Act), and other applicable federal and state laws.

## **2.7 Provider Reimbursement**

### ***General***

The Department 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. The MCO must also require all claims for payment for items or services that were ordered to contain the National Provider Identifier (NPI) of the physician or other professional who ordered or referred such items or services.

### ***In-Network Services***

Subject to Article III, 2.7, Timely Payment Requirement, the MCO must make timely payment within 30 calendar days for medically necessary, covered contract services rendered by in-network providers when:

1. Services were rendered to treat a medical emergency, or
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***

Subject to Article III, 2.7, Timely Payment Requirement, the MCO must make timely payments to out-of-network providers for medically necessary, covered services when:

1. Services were rendered to treat a medical emergency, or
2. Services were for family planning and sexually transmitted diseases, or

3. Services were prior authorized.

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

### ***Emergency Services***

When emergency services are provided to an enrollee of the MCO, the MCO's liability for payment is determined as follows:

1. **Presence of a Clinical Emergency:** If the screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition exists, the MCO must pay for both the services involved in the screening examination and the services required to stabilize the patient.
2. **Emergency Services Continue Until the Patient Can be Safely Discharged or Transferred:** The MCO is required to pay for all emergency services which are medically necessary until the clinical emergency is stabilized. This includes all treatment that may be necessary to assure, within reasonable medical probability, that no material deterioration of the patient's condition is likely to result from, or occur during, discharge of the patient or transfer of the patient to another facility. If there is a disagreement between a hospital and the MCO concerning whether the patient is stable enough for discharge or transfer, or whether the medical benefits of an unstabilized transfer outweigh the risks, the judgment of the attending physician(s) actually caring for the enrollee at the treating facility prevails and is binding on the MCO. The MCO may establish arrangements with hospitals whereby the MCO may send one of its own physicians with appropriate Emergency Room privileges to assume the attending physician's responsibilities to stabilize, treat, and transfer the patient.
3. **Subsequent Screening and Treatment:** An enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition.
4. **Notification of Enrollee's PCP:** The MCO may not refuse to cover emergency services solely based on the emergency room provider or hospital not notifying the enrollee's primary care provider, MCO, or BMS of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services. Nothing in 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 PCP or other MCO representative instructs the beneficiary to seek emergency care in-network or out-of-network, the MCO is responsible for payment for the medical screening examination and for other medically necessary emergency services, without regard to whether the patient meets the prudent layperson standard described above.

The MCO must promptly pay for all covered emergency services, including medically necessary testing to determine if a medical emergency exists, that are furnished by providers that do not have arrangements with the MCO. This includes emergency services provided by a non-participating provider when the time required to reach the MCO's facilities, or the facilities of a provider with which the MCO has contracted would have meant risk of permanent damage to the enrollee's health.

### ***Critical Access Hospitals***

MCOs contracting with Critical Access Hospitals (CAH) must make payment to CAH at the prevailing Medicaid reimbursement rate. MCO contracts with CAH must stipulate this reimbursement arrangement. Upon BMS notification to the MCO of any changes to the CAH reimbursement rates, the MCO must update payment rates to CAH effective from the designated 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 must pay all clean in-network provider claims for covered services within 30 calendar days of receipt, except to the extent the provider has agreed to later payment in writing.

The MCO must pay all electronic out-of-network clean claims within 30 days and all paper out-of-network clean claims within 40 days from the date of receipt, except to the extent the provider has agreed to later payment in writing.

The MCO must agree to specify the date of receipt as the date the MCO receives the claim, as indicated by its date stamp on the claim, and date of payment as the date of the check release or other form of payment release to the provider.

The MCO must pay in-network providers interest at 7% per annum, calculated daily for the full period in which the clean claim remains unpaid beyond the 30-day clean claims payment deadline. Interest owed to the provider must be paid on the same date as the claim. The interest paid to the providers will not be reported as a part of the MCO encounter data.

### **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 in accordance with 42 CFR 438.6. The MCO will track PPC data and make it available to BMS upon request.

### **2.8 Prohibitions on Inappropriate Physician Incentives**

The MCO must comply with regulatory requirements regarding physician incentives as specified in 42 CFR 417.479, 42 CFR 438.6(h), 42 CFR 422.208, and 42 CFR 422.210. The MCO may not make specific payment, directly or indirectly, to a physician or physician group as an inducement to reduce or limit medically necessary 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 must comply with any additional rules regarding physician incentives released by CMS.

### **3. ENROLLMENT & MEMBER SERVICES**

The program will enroll the TANF, TANF-related populations, and adults eligible for the Medicaid Alternative Benefit Plan (ABP), including certain low income populations eligible under the authority of The Patient Protection and Affordable Care Act. Enrollment 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 Medicaid managed care programs. The enrollment broker will use the marketing materials furnished by the MCO as set forth in this contract to assist enrollees in choosing an MCO. The enrollment broker will be responsible for notifying potential enrollees about their MCO choices; answering questions about the MCO; and for assisting the enrollee in completing any paperwork necessary to enroll in the MCO, to disenroll from the MCO, and to transfer from one MCO to another. The MCO will be furnished with an enrollment roster that identifies individuals enrolled in the MCO, including all new enrollees, on a monthly basis. All enrollment activities are subject to the standards and requirements set forth in this contract.

#### **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. The MCO marketing plan must comply with the BMS Marketing Policies as described in Exhibit D of this Contract.

##### ***Marketing Materials***

The MCO must follow the marketing guidelines as described in 42 CFR 438.104 and Exhibit D, BMS Marketing Policies. The MCO must develop marketing materials for the enrollment broker to assist Medicaid enrollees with their MCO selection. The MCO must include a Medicaid 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<sup>8</sup> and provide a written assurance that marketing materials do not mislead, confuse or defraud recipients or BMS. Such written assurance must be provided annually or with each submission of new or revised marketing materials. Statements that will be considered inaccurate, false, misleading include, but are not limited to, any assertion or statement (whether written or oral) that:

- The potential enrollee must enroll in the MCO in order to obtain benefits or in order to not lose benefits; or
- The MCO is endorsed by CMS, the federal or state government, or similar entity.

Marketing materials that require BMS review and approval include but are not limited to:

1. Marketing materials to potential members
2. Member materials (Provider Directories, Member Handbooks, Member ID cards, etc.)
3. Information to be used on the MCO's Website or the Internet
4. Print media
5. Television and radio storyboards or scripts
6. Member participation materials

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

## **3.2 Enrollment**

### ***Process***

The MCO will conduct continuous open enrollment during which the MCO must 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 may 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

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<sup>8</sup> Many commercial word processing software programs contain utilities for testing the readability of documents produced using the program.

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 as described in Article III, Section 5.6.

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

Notwithstanding Article III, Section 7.6, Responsibility for Inpatient Care, if a member 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 member is transferred during the stay, or within the facility) will be the responsibility of BMS until the member is discharged. The MCO is responsible for all other covered services provided on or after the effective date of MCO enrollment, including but not limited to emergency transportation, professional fees during the inpatient stay and outpatient care.

The MCO is responsible for all charges during the inpatient newborn stay if such newborn is born to a mother who is a current MCO member until the newborn's discharge.

#### *Automatic Reassignment Following Resumption of Eligibility*

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

#### *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 will be counted as day one. BMS will pay a full month's capitation for all newborns. The MCO will receive capitation payments for all subsequent months that the child remains enrolled with the MCO. The MCO must submit newborn enrollment forms to the enrollment broker within 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. The beneficiary's permanent residence changes to a location outside the MCO's Medicaid service area. However, if the resident moves to a location serviced by other MCOs, the resident must reenroll into a new MCO as soon as administratively possible.
3. Continuous placement in an inpatient facility, nursing facility, State institution or intermediate care facility for the mentally retarded for more than 30 calendar days.
4. Error in enrollment. This may occur if the beneficiary was inaccurately classified as eligible for enrollment in an MCO, if the beneficiary does not meet the eligibility requirements for eligibility groups permitted to enroll in an MCO, or after a request for exemption is approved if the enrollment broker enrolled the beneficiary while their exemption request was being considered.
5. 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. In the case of continuous placement in a facility or institution for more than 30 calendar days, the MCO must notify BMS within 5 business days following the 30<sup>th</sup> day of admission. The enrollment broker will then notify the beneficiary or family and update the enrollment roster to inform the MCO of disenrollment. The effective date of the disenrollment will be no later than the first day of the second month after the month in which the MCO requests termination. When notifying BMS of its intent to disenroll a member, the MCO must specify the reason for the request in order to assure BMS that the reason for the request is consistent with the permissible reasons specified in this contract. BMS will make the final decision to approve or deny the requested MCO-initiated disenrollment. If BMS does not act on the MCO's request for a disenrollment, the disenrollment will be considered as approved.

#### *Enrollee-Initiated Disenrollment*

MCO enrollees may request disenrollment at any time for any reason. Disenrollment will be effective no later than the first day of the second month after the month in which the enrollee requests disenrollment. There is no limit on the number of disenrollment requests that an enrollee can initiate. The enrollee should contact the enrollment broker to initiate disenrollment. However, if an enrollee informs the MCO that he or she wants to transfer to another MCO, the MCO must work with the enrollment broker to facilitate the process. If an enrollee makes multiple requests before the next effective date, the enrollment broker will transfer the individual to the last MCO selected prior to the enrollment closing date.

### **3.3 Member Services Department**

#### ***General Requirements***

The MCO must maintain a Member Services Department to assist members in obtaining Medicaid covered services. The Member Services Department, at the minimum, must be accessible during regular business hours, at least for 8 hours a day 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.

The MCO must ensure that the member services phone line meets the following minimum performance requirements:

1. Eighty three percent (83%) of calls are answered live within thirty (30) seconds during operating hours. Time measured begins when the member is placed in the call queue to wait to speak to a Member Services representative;
2. The call abandonment rate does not exceed five (5) percent of total calls for the reporting period.

The MCO must administer a brief member survey (10-15 questions) quarterly. The survey content and method of delivery is to be developed by the MCO addressing areas related to member satisfaction and may include The National Committee for Quality Assurance (NCQA) required surveys. The survey tool and results must be reported to the Department no later than the 15th day of the second month following the end of the reporting period. The report must include any identified areas for improvement and planned action items.

### **3.4 Materials**

#### ***Enrollee Information***

The MCO must provide all paper and electronic informational materials relating to the Medicaid program in a manner and format consistent with the requirements of 42 CFR § 438.10. 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 5 business days of enrollment. The MCO may issue one identification



card for all covered benefits except for a dental benefit card, which may be issued separately. PCP information must be updated as soon as it becomes available. The MCO must issue a replacement card within 5 business days of a member's request.

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;
7. TTY number;
8. Notice that the member must present both the MCO card and the Medicaid card at time of service; and
9. The Medicaid program type (Mountain Health Trust or West Virginia Health Bridge).

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 must mail an enrollee handbook to the enrollee's household within 5 business days of official enrollment notification to the MCO. The MCO must provide periodic updates to the enrollee handbook as needed explaining changes to the MCO policies or Medicaid program. When there are program or service site changes, notification will be provided to the affected enrollees at least fourteen calendar days before intended effective date of the change. The MCO must maintain documentation verifying that the member handbook is reviewed at least once a year. The MCO must mail an updated member handbook to its enrollees at least annually after initial enrollment. The MCO must publish and keep current its member handbook on the MCO website. The MCO must provide a member handbook to enrollees within 5 business days 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 must 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 MHT or WVHB contract services including amount, duration, scope and how to access those services (e.g., whether the enrollee can self-refer to the service or if a referral or prior authorization is needed); and an explanation of any service limitations or exclusions from coverage;
4. 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-network and out-of-network, Medicaid-participating family planning providers;
9. Information concerning policies on advance directives;
10. 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;
11. The fact that prior authorization is not required for emergency services;
12. The enrollee's right to use any hospital or other setting for emergency care;
13. Procedures for obtaining services covered under the Medicaid state plan and not covered by the MCO (e.g., non-emergency medical transportation );
14. The extent to which and how to access post-stabilization services;
15. Limited MCO liability for services from non-MCO providers, e.g., only emergency care or referrals;
16. The phone number of the enrollment broker;
17. Information about choosing and changing PCPs;

18. Information about what to do when family composition changes;
19. Appointment procedures and access standards including travel time, scheduling standards and the MCO's standard waiting time;
20. Guidance to seeking care when out-of-area services are required, including authorization requirements and process;
21. How to obtain emergency transportation, medically necessary transportation and non-emergency transportation;<sup>9</sup>
22. How to obtain maternity and sexually transmitted diseases services;
23. How to obtain behavioral health services;
24. How to obtain non-emergency and emergency dental services;
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;<sup>10</sup>
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;
33. The MCO must advise enrollees at least annually of their right to request and obtain the above information;
34. Cost-sharing policies, including but not limited to exemptions for certain categories of members and services; and
35. Policies regarding the use of oral interpreters for minors and in case of emergency.

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;

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<sup>9</sup> The MCO should contact the county BMS office to obtain information on how enrollees can obtain non-emergency transportation and medically necessary transportation.

<sup>10</sup> 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.

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.

### ***Provider Directory***

The provider directory must include the names, locations, and telephone numbers of current contracted providers in the enrollee's service area, as well as the non-English languages spoken by those providers, identify providers that are not accepting new patients, and inform of any restrictions on the enrollee's ability to select from among network providers. This information should include, at a minimum, information on primary care physicians, specialists, pharmacies, general pediatric dentists, behavioral health providers, and hospitals.

The MCO must give affected enrollees reasonable notice of any changes regarding providers. The MCO must furnish a written notice of any change in the names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area, including identification of providers that are not accepting new patients, at least 30 days before the intended effective date of the change.

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 must provide potential enrollees a copy of the provider directory, upon request. The MCO must publish and keep current its provider directory on the MCO website. The MCO must provide enrollees a copy of its provider directory, upon request within 5 business days.

### ***Internet Website***

The MCO must develop and maintain a website to provide general information about the Medicaid managed care programs, the provider network, customer services, and the complaints and appeals process. The MCO must ensure that enrollees have access to the most current and accurate information concerning the MCO's network provider participation.

## **3.5 Education**

### ***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 Trust and West Virginia Health Bridge, the MCO must provide tobacco cessation benefits for pregnant women, adults, and children respectively. The MCO is not required to provide weight management services; the MCO may provide these services as a value-added service except for bariatric surgery which is a covered benefit under the State Plan.

Additional health education and preventive care programs may be provided that address the social and physical consequences of high-risk behaviors. Examples include programs on the prevention of HIV/AIDS, unintended pregnancy, violence, 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 must 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 must instruct each enrollee that receives a screen to contact his or her PCP if medical follow-up is necessary and must ensure that each enrollee receives a printed summary of the assessment information to take to his or her PCP. The MCO is encouraged to transmit a summary of the assessment information directly to each enrollee's PCP.

### ***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.

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 an 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 is required to provide oral interpretive services for languages on an as-needed basis. These requirements extend to both in-person and telephone communications to ensure that enrollees are able to communicate with the MCO and providers and receive coverage benefits. Oral interpretative services must be provided free of charge to enrollees and potential enrollees and must be available for all non-English languages. The MCO must also provide audiotapes for the illiterate upon request.



BMS will periodically review the degree to which there are any prevalent language or languages spoken by Medicaid beneficiaries in West Virginia (cultural groups that represent at least 5 percent of the Medicaid population). Within 90 days of notification from BMS, the MCO will make written materials available in prevalent non-English languages in its service areas. At the current time, there is no data to indicate that West Virginia has any Medicaid populations that meet this definition.

The MCO must notify enrollees and potential enrollees of the availability of oral interpretation services for any language and written materials in prevalent non-English languages. The MCO must also notify enrollees and potential enrollees of how to access such services.

### ***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 must encourage and foster cultural competency among its providers. Culturally appropriate care is care given by a provider who can relate to the enrollee and provide care with sensitivity, understanding, and respect for enrollee's culture and background.

### ***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 and appeals procedures must be understandable and accessible to Medicaid enrollees and must comply with federal requirements and West Virginia Statutes 33-25A-12, and must be approved in writing by 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 enrollee may file an appeal to seek a review of an adverse action taken by the MCO as defined in 42 CFR 438.400(b). The MCO must 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 must establish and maintain a grievance and appeal procedure, which has been approved by the State, to provide adequate and reasonable procedures for the expeditious resolution of grievances initiated by enrollees or their providers concerning any matter relating to any provision of the MCO's health maintenance contracts, including, but not limited to, claims regarding the scope of coverage for health care services; denials, reductions, cancellations or 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 must be included in the member handbook provided to enrollees. This procedure must be administered at no cost to the enrollee.
  - c. As part of MCO's enrollee grievance and appeal procedure, the MCO must:
    - i. Make available 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 must 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 grievances must provide that:

- a. An address must be included for written appeals and formal grievances;
  - b. A provider may file an appeal on the enrollee's behalf with the enrollee's written consent;
  - c. No punitive action may be taken against a provider who files an appeal on behalf of an enrollee or supports the enrollee's appeal;
  - d. If an expedited appeal or review of a 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 grievance as well as other documents considered during the appeal. Parties to the appeal must include the enrollee, his representative, or legal representative of a deceased enrollee's estate;
  - f. The time limit for the enrollee to file an appeal or grievance is 90 days from the date on the notice of action;
  - g. The MCO must offer to meet with the enrollee during the grievance process;
  - h. The MCO must maintain an accurate record of each appeal and grievance;
  - i. Copies of the grievances and the responses thereto must be available to the public for inspection for three years;
  - j. The MCO must process and provide notice to affected parties regarding the appeal or grievance in a reasonable length of time not to exceed 45 days from the day the MCO receives the appeal or 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 must give the enrollee written notice of the reason for the delay; and
  - m. MCOs must provide written notice of the disposition of appeals which will include: the result, the date of the resolution, the right and procedure to request a state fair hearing, the right to receive continuation benefits while the hearing is pending, how to make the request for continuation benefits, and potential enrollee liability for the cost of continuation benefits if the state fair hearing upholds the MCOs decision.
3. The MCO must establish and maintain a process for the review and resolution of requests for an expedited appeals process regarding any denial, termination, or reduction of services, which could seriously jeopardize the enrollee's health and well-being. This includes an appeal regarding any service related to a member's formal treatment plan as developed by the MCO and PCP. The MCO must report these appeals to BMS immediately, and BMS will then determine the timeline for resolving the

appeals. The expedited process for appeals must meet the requirements of Subsections 1 and 2 above and also must provide that:

- a. Expedited review of appeals is available upon request of the enrollee or provider if the MCO determines that the timeframe for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function;
  - b. If a request for an expedited appeal is denied, the MCO must transfer the appeal to the standard resolution timeframe and make reasonable effort, as defined by BMS, to provide prompt oral notice to the enrollee, followed up with written notice within two calendar days;
  - c. The MCO must inform the enrollee of the limited time available to present in writing or orally, evidence and allegations of fact or law;
  - d. Resolution and notice for an expedited appeal must occur within the shorter of 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 must make reasonable effort to provide oral notice of disposition of an expedited appeal; and
  - f. If the timeframe for resolving an expedited appeal is extended for any reason other than an enrollee request, the MCO must give the enrollee written notice of the reason for the delay.
4. Review of Appeal Decisions

None of the foregoing procedures precludes the right of enrollees to request a fair hearing before the Department of Health and Human Resources as part of an enrollee's right to fair hearing related to applications for eligibility and decisions to suspend, terminate, or reduce services as specified in 42 CFR 431.220 and 42 CFR 438.400. The MCO must implement any decision made by 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 must 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 will 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 must 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 must 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 must 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.

The MCO must resolve at least 98% of member appeals within 45 calendar days from the date the appeal is filed with the MCO, unless the enrollee requests an extension or the MCO shows that a delay is necessary and in the interest of the enrollee.

### **3.9 Cost-Sharing Obligations**

The MCO, through the MCO's providers, must impose copayments for covered services in the amounts that are determined by the Department in accordance with the requirements specified in the State Plan and the requirements set forth in 42 CFR §§447.50 -447.57.

The MCO must reduce payments to the network providers by the amount of the member's copay, regardless of whether the provider successfully collects the copay. The MCO, or the MCO's providers, may not routinely waive required copays.

Pharmacy co-payments must be assessed on the total allowed charge for the prescription, regardless of preferred or non-preferred status.

The MCO must have a process to track a quarterly household maximum for the cost-sharing obligations based on the members' Federal Poverty Level (FPL).

#### ***Members exempt from cost-sharing obligations***

The MCO and the MCO's providers may not charge copays to the following MCO members or on the following services:

- Family planning services;
- Emergency services;
- 72-hour emergency supply of medication;
- Following pharmacy services: diabetic testing supplies, syringes and needles, and home infusion supplies approved by the Department;
- Members under age 21;
- Pregnant women (including the 60-day postpartum period following the end of pregnancy);
- American Indians and Alaska Natives;
- Members receiving hospice care;
- Members in nursing homes;
- Any additional members or services excluded under the State Plan authority; and
- Members who have met their household maximum limit for the cost-sharing obligations per calendar quarter.

#### ***Services and members subject to cost-sharing obligations***

The MCO and the MCO's providers must charge copays for the following MCO services or members:

- Inpatient and outpatient services;

- Physician office visits, including but not limited to, office visits to a psychiatrist or a nurse practitioner;
- Pharmacy medications;
- Non-emergency use of an emergency department;
- Caretaker relatives age 21 and up;
- Transitional Medicaid members age 21 and up; and
- Any other members identified by the MCOs that are not specifically exempt.

### **3.10 Value-Added Services**

The MCO may propose to offer Value-Added Services. If offered, the MCO will not receive additional compensation for the Value-Added Services from the Department. The MCO may report the costs of Value-Added Services as allowable medical or administrative costs for the purposes of Medical Loss Ratio calculation. The cost of Value-Added Services is not included in the MCO capitation rates. The Value-Added Services are not included in the Medicaid benefit package.

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

- By November 1 of each calendar year for the January 1 publishing date; and
- By May 1 of each calendar year for the July 1 publishing date.

For each Value-Added Service proposed, the MCO must:

- Define and describe the Value-Added Service;
- Specify the applicable service areas for the proposed Value-Added Service;
- Identify the category, group or managed care program of members eligible to receive the proposed Value-Added Service if it is a type of service that is not appropriate for all members;
- Note any limitations or restrictions that apply to the Value-Added Service; and
- Describe if, and how, the MCO will identify the Value-Added Service in the encounter data.

Since Value-Added Services are not Medicaid covered services, there is no appeal or fair hearing rights for a member regarding these services. A denial of a Value-Added Service will not be considered an adverse action. The MCO must notify a member if a Value-Added Service is not approved. No-copays may be imposed for the Value-Added Services.



#### **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 must ensure that the cost to the enrollee is no greater than it would be if the services were furnished within the network. Services must be covered as adequately and timely as if such services were provided within the network, and for as long as the MCO is unable to provide them. To the extent possible, the MCO must encourage out-of-network providers to coordinate with the MCO with respect to payment.

### **5.3 Continuity and Coordination of Care**

The MCO must ensure continuity and coordination of care through use of an individual or entity that 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.. 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 (Prior Authorization)**

The MCO must adopt service authorization requirements that comply with state and federal laws governing authorization of health care services and prescription drug benefits. The MCO must develop, maintain, and implement written policies and procedures, reflecting current standards of medical practice, for processing requests for initial authorization of services or requests for continuation of services. The policies must provide for consultation with the requesting provider when appropriate and must have mechanisms to ensure consistent application of review criteria and compatible decisions. The policies must specify information sources and the process used to review 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 must ensure that the services are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished.

Decisions to deny service authorization or to authorize a service in amount, duration or scope that is less than requested must be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease and who has knowledge of local patterns of care, as determined by BMS. The MCO may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary. The MCO may place appropriate limits on a service on the basis of criteria such as medical necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose.

Admission, continued stay, and discharge criteria used by the MCO 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 no later than 7 (seven) calendar days of receiving the request for service for the purposes of standard authorization decisions. This 7 (seven) calendar days period may be extended up to 7 (seven) additional calendar days upon request of the enrollee or provider, or if the MCO justifies to BMS in advance and in writing that the enrollee will benefit from such 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, but no later than 3 business days after receipt of the request for service authorization. This 3 business day period may be extended up to 5 additional business days upon request of the enrollee or provider, or if the MCO justifies to BMS in advance and in writing that the enrollee will benefit from such 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.

### ***Continuity of Care***

The MCO must ensure that the care of enrolled members is not disrupted or interrupted.

The MCO cannot require service authorization as a condition for payment for emergency care. The MCO cannot require service authorization for family planning services whether rendered by a network or out-of-network provider.

The MCO must provide 30 days' notice to providers before implementing changes to policies and procedures affecting the service authorization process. However, in the case of suspected fraud, waste, or abuse by a single provider, the MCO may implement changes to policies and procedures affecting the service authorization process without the required notice period.

Upon the receipt of the prior service authorization documents from a member or provider of the existence of a service authorization, the MCO must ensure members receiving services through a service authorization from either another MCO or FFS receive continued authorization of those services for the same amount, duration, and scope for the shortest period of one of the following: (1) until the end of the current authorization period as granted by either another MCO or FFS, or (2) until the MCO has evaluated and assessed the member and issued or denied a new service authorization.

## **5.5 Rural Option**

If the MCO is the single MCO contracted to provide services in a rural county as permitted in 42 CFR 438.52, the MCO will permit enrollees to choose from at least two 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 TANF or SSI enrollee will be transitioned to a participating provider within 60 days or 90 days, respectively, 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;

5. Coordination and provision of EPSDT services as defined in Article III, Section 1.2;
6. Policies and procedures that ensure the completeness of the case management record to include all results of referrals, consultations, inpatient records, and outpatient records.

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, pharmacy 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 in-network providers to educate members about the release of necessary medical data to the MCO.

The MCO must ensure that enrollees who seek family planning services from the plan are provided with counseling regarding methods of contraception; HIV and sexually transmitted diseases and risk-reduction practices; and options to pregnant enrollees who may wish to terminate their pregnancies. The MCO will make appropriate referrals as necessary. All family planning services will be included in the encounter data that all health plans must report to BMS.

#### ***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 must complete identification and assessment of the individuals with complex or serious medical conditions within 90 days of the effective date of enrollment in the MCO. The MCO must use appropriate health care professionals in assessing those conditions, identifying medical procedures to address and/or monitor the conditions, and developing treatment plans appropriate for those enrollees determined to need a course of treatment or regular care monitoring. Treatment plans must 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; must be approved by the MCO in a timely manner if such approval is required; and must meet applicable quality assurance and utilization standards. These treatment plans must be time-specific and updated periodically by the primary care provider.

If the enrollee's condition is one of the chronic conditions defined in the Medicaid State Plan as qualifying for a chronic condition health home, the MCO must notify the enrollee of the availability of designated health homes for his or her condition.

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 must ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with the requirements of 42 CFR parts 160 and 164 subparts A and E, to the extent they apply.

The MCO must have trained staff available to assist in the development of a clinical treatment plan and to work with the 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.

#### *Associations with the Title V State Agency*

The MCO, through the Department, will coordinate with the Bureau for Public Health, Office of Maternal, Child and Family Health, to:

1. Help to ensure that all enrolled members with special health care needs, ages 0 to 21, receive comprehensive, coordinated services and supports pursuant to national standards for systems of care for children and youth with special health care needs;
2. Assure better access to and receipt of the full range of screening, diagnostic, and treatment services covered under EPSDT.

The Department, the Bureau for Public Health, Office of Maternal, Child and Family Health and the MCO will establish a Memorandum of Understanding to implement coordination strategies to better serve children under the age of 21, including those individuals with special health care needs, who are eligible for Medicaid managed care services.

### **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 must satisfy the requirements for standard and expedited authorization of services, authorization criteria, and notice. The MCO must meet BMS-specified standards for utilization management (service authorization) listed in this contract.

For beneficiaries that have primary insurance coverage from a source other than Medicaid, the MCO must honor coverage and utilization management decisions made by the primary carrier for those services in the primary carrier's benefits package. If the MCO is responsible for Medicaid services that are carved out of the primary carrier's benefit package, the MCO has utilization management responsibility for those carved out services.

### **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 must 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 marital 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; and
- Information needed to conduct utilization review as specified in 42 CFR 456.111 and 42 CFR 438.211.

Medical records must 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 must 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 must be protected by the MCO from unauthorized disclosure. The MCO must provide safeguards that restrict the use or disclosure of information concerning enrollees to purposes directly connected with the administration of this contract. 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 are confidential and may not be released without the written consent of the covered persons or responsible party, except as specified below.
  - a. Written consent is not required for the transmission of medical record information to physicians, other practitioners, or facilities that are providing services to enrollees under a subcontract with the MCO. This provision also applies to specialty providers who are retained by the MCO to provide services that are infrequently used or are of an unusual nature. This also allows for transfer of information (written or verbal) to BMS staff and to BMS subcontractors.
  - b. Written consent is not required for the transmission of medical record information to physicians or facilities providing emergency care, or to the MCO, its staff, contracted providers or its contractors that are providing cost, quality, or medical appropriateness reviews or coordination of benefits or subrogation.
  - c. Written consent is required for the transmission of the medical record information of a former enrollee to any physician not connected with the MCO, except as set forth in (ii) above.

2. The extent of medical record information to be released in each instance will be based upon tests of medical necessity and a "need to know" basis on the part of the practitioner or a facility requesting the information. Medical records maintained by subcontractors must meet the above requirements.

### **5.11 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. All MCO reports submitted under this contract must reflect MHT and WVHB program-related data only unless otherwise requested by the Department.

The MCO must certify data submitted to BMS and an authorized agent of BMS, if such data is the basis upon which BMS payments are made to the MCO. The data must be certified by the MCO's Chief Executive Officer (CEO) or Chief Financial Officer (CFO), or an individual who has authority to sign for and who reports directly to the MCO's CEO or CFO. The MCO must submit the certification concurrently with the certified data. The format for the data certification is included as Exhibit F. The data that must be certified include, but are not limited to, enrollment information, encounter data, and other information required by the Department and contained in contracts, proposals, and related documents.

#### ***Quarterly Reports***

The MCO must provide BMS with quarterly reports summarizing provider network, utilization, quality, access, EPSDT, and financial data in formats to be specified by BMS, no later than by the 15th day of the second month following the end of the reporting period.

The quarterly report must provide information on the number of medically necessary services contained within the categories of mandatory and optional services listed in Section 1905(a) of the Social Security Act but not covered under the State Plan.

#### ***Grievance and Appeals Reporting***

The MCO must provide BMS with quarterly reports documenting the number and types of informal and formal grievances and appeals registered by enrollees and providers, and the status or disposition of all grievances and appeals. Reports must be submitted no later than the 15th day of the second month following the end of the reporting period. At a minimum the reports 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 coverage 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.
- Average appeals resolution timeframe and percentage of appeals resolved within 45 days. The MCO must provide the total number of appeals resolved after the required timeframe of 45 days and the reason for the extended resolution time.

### ***Member Satisfaction Reporting***

The MCO must survey a sample of its adult and child members at least annually to determine member satisfaction with the quality of MCO care and services. The MCO must use the latest available version of the Consumer Assessment of Health Plans (CAHPS) survey. The survey tool should support reporting of the U.S. Department of Health and Human Services' Core Quality Measures for Adults and Children. The MCO must use content or methodology as directed by BMS. The MCO must submit to BMS a copy of any results submitted to NCQA within five business days of submission to NCQA.

A comprehensive analysis of survey results must be reported to BMS annually, on or before August 15. The analysis must include the methodology, overall response rate, and results for global ratings, composite scores, item-specific question summary rates, and any other measure specified by BMS. If BMS requires any additional measures to be reported from the survey results, BMS will notify the MCO at the time it approves the survey tool.

The MCO must use survey results to identify and investigate areas of enrollee dissatisfaction, outline action steps to follow-up on the survey findings, and share findings with providers. Concurrent with submission of the analysis of survey results on August 15, the MCO must submit its action plan to BMS. The action plan must include implementation steps, a timeline for completion, and any other elements specified by BMS. After the first submission, the MCO must submit updates on its progress in implementing the action plan 45 days after the end of each quarter.

### ***Encounter Reporting***

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

The MCO is responsible for submitting complete and accurate encounter data for all services rendered that fall within the defined benefit package. Complete and accurate encounter data must be submitted monthly and no later than 30 calendar days after the end of the period in which the service was paid. Encounter data must follow the format and data elements as required by the HIPAA-compliant 837 transaction for medical and dental claims, and D.0 transaction for pharmacy claims. Along with the encounter data submission, the MCO must submit:

- A detailed summary of the file submission to include total claims and dollars by service category;
- A detailed change log to include specifications for any change in the claims processing systems that has an impact of the representation of the data on the monthly encounter files. Examples of such changes include, but are not limited to, correction and adjustment processing, range and domain of extract variables, values of extract variables, and relationships between extract variables; and
- A dictionary containing definitions for all codes contained on the encounter record that are not defined in the public domain. Such variables include but are not limited to, provider specialty, type of service, place of service, and internal procedure codes.

The MCO must reconcile the encounter data submitted to BMS to the financial data that it reports to BMS on a quarterly basis. The MCO must submit this reconciliation to BMS by the 15th day of the second month following the end of the reporting period, along with the financial data. The MCO must explain differences of 5% or higher.

The MCO must have a data accuracy and completeness monitoring program in place that:

- Demonstrates that all claims and encounters submitted to the MCO by health care providers, including subcontractors, are submitted accurately and timely as encounters to BMS;
- Evaluates health care provider and subcontractor compliance with contractual reporting requirements; and
- Demonstrates that the MCO has the processes in place to act on the information from the monitoring program and takes appropriate action to ensure full compliance with the encounter reporting requirement.

The MCO must submit an annual Data Accuracy and Completeness Plan to BMS for review and approval by October 1<sup>st</sup> for the current fiscal year. This Plan must include the three elements listed above. Along with this submission, the MCO should submit documentation of its data file layout.

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 must attest to the truthfulness, accuracy, and completeness of all encounter data each time data is submitted to BMS. Claims certificate is required from each provider submitting data to the MCO. The MCO must require its physicians who provide Medicaid services to have

a unique identifier, which 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. The MCO will be required to comply with any changes that BMS intends to implement within 60 days of issuance, unless otherwise agreed to in writing by BMS within 30 days of issuance.

The MCO must provide BMS with a written notice at least 90 days prior to any system conversions and changes in coding. It must also provide a plan to work with BMS to ensure consistency of encounter data.

The MCO must provide complete, accurate, and timely encounter data to BMS. If previously submitted encounter data is identified with a significant number of errors, the MCO will be required to re-submit corrected encounter data within 30 days of notification from BMS.

### ***HEDIS Reporting***

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

### ***National Core Health Care Quality Measures Reporting***

The Secretary of the Department of Health and Human Services has identified a set of core health care quality measures for Medicaid-eligible adults and children enrolled in Medicaid and CHIP. The MCO must report annually to BMS results for all identified core adult and child quality measures relevant to the contract covered services following the technical specifications provided by CMS. Results for the previous calendar year are due on or before September 1. The MCO must use the most recent technical specifications from CMS, available at [www.medicaid.gov](http://www.medicaid.gov), to calculate results.

### ***Financial Reporting***

Regular reporting is necessary to assure the ongoing operation and financial integrity of participating MCOs. The MCO must provide financial reports as specified by this Contract. Plans that are in a particularly weak financial position may be required to report more frequently.

1. *Annual Financial Statements:* Annually, on or before June 1, the MCO must submit audited financial statements.
2. *West Virginia Offices of the Insurance Commissioner (OIC):* The MCO must submit copies of its quarterly and annual OIC reports, as well as any revisions thereto. The MCO must include applicable OIC reports on the solvency of its intermediaries. These reports are due on the same due dates for reporting to the OIC. Any revisions to a quarterly and/or annual OIC report must be submitted on the same day on which the report is submitted to the OIC.

The MCO must comply with all other financial reporting requirements as outlined in Article III, Section 7.

### ***Provider Network Reporting***

The MCO must comply with reporting requirements required to assess compliance with network standards in a format and frequency to be specified by BMS.

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

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

MCOs must submit yearly statements to BMS each year by October 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 must 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***

The MCO must 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. The MCO must resolve any disputes related to the data within 60 days from notification of BMS.

### ***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***

The MCO must 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 must include several distinct, but interrelated comprehensive strategies and must be designed to achieve, through ongoing measurements and intervention, significant improvement in clinical and nonclinical areas of care that are expected to have a favorable effect on health outcomes and 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 annually. Projects must be completed within a reasonable timeframe. The basic elements of the MCO's QAPI must comply with the requirements set forth in this contract.

The MCO must also cooperate with BMS initiatives aimed at assessing and improving program performance. These initiatives can include regular reporting to the State and an annual external quality review consisting of an on-site systems performance review of quality outcomes, timeliness of, and access to services covered under this contract. The MCO must make every effort to comply with external quality reviews that will be implemented by an organization contracted by BMS. This may include participating in the design of the external review, collecting medical records and other data, and/or making data available to the external quality review organization.

### **6.1 Required Levels of Performance**

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

### **6.2 Mountain Health Trust (MHT) Performance Withhold**

Beginning July 1, 2014, the Department will place each MCO at risk for five percent (5%) of the MHT capitation payment by withholding that amount from the monthly MHT program

capitation paid to the MCO by the Department under Article III, 7.2. The resulting rate, net of the withhold, must meet actuarial soundness requirements. The Department's objective is that the MCO achieve performance standards that enable the MCO to earn the 5% withhold back.

The Department will identify no more than ten performance measures for the MCO per calendar year (see Exhibit G for reference). The performance measures and methodology will be evaluated annually by the Department and the MCO. The performance measures must be based on the relevant MHT program goals with consideration of nationally recognized benchmarks, and must promote the goal of continuous improvement in the MHT program.

On an annual basis, the Department or its designee will evaluate whether the MCO has demonstrated that it has fully met the performance measures for which the MCO is at risk. The Department or its designee will determine the extent to which the MCO has met performance measures by assessing each MCO's report relative to performance targets for the corresponding calendar year. If the MCO does meet some or all of the performance measures, the Department will issue a portion or entire sum of the withheld capitation as a lump sum payment to be paid no later than November of each corresponding year. The payment made no later than November of each year will be based on the MCO performance in the previous calendar year (e.g., November 2017 payment will be made based on calendar year 2016 performance). The Department will conduct separate accounting for each MCO.

The MCO must submit all performance reports and data related to the performance withhold during the annual performance measure validation. The MCO's failure to timely provide the Department with necessary data related to the calculation of the performance withhold will result in assignment of a zero percent (0%) performance rate for each related performance measure.

### **6.3 Performance Improvement Projects**

The MCO must develop and maintain written descriptions of its performance improvement program, including the identification of individual(s) responsible for the program. The MCO must conduct MHT and WVHB 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**

The MCO must initiate<sup>11</sup> and maintain performance improvement projects that address the focus areas specified above. The MCO must maintain at least three projects at a time. The performance improvement projects may be selected by BMS and may include the same areas of focus as the Performance Withhold, Article III, Section 6.2. In cases where BMS does not specify a project focus, the MCO may select a specific topic within one of the identified focused areas. Project proposals must be approved by BMS and the EQRO prior to project initiation.

The topics 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. The MCO will assess its performance on its selected indicators by collecting and analyzing reliable data on an on-going basis. The MCO must establish a baseline measure of its performance on each indicator, measure changes in performance, and continue measurement for at least one year after a desired level of performance is achieved. The MCO must annually submit performance measurement data to BMS using BMS-determined standard measures, including performance measures that may be developed by CMS.

If sampling is used, the MCO's sampling methodology must ensure that the data collected validly reflect the performance of all providers whose activities are the subject of the indicator;

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<sup>11</sup> 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).

and the care given to the entire population (including special populations with complex care needs) to which the indicator is relevant.

The MCO must also demonstrate that its interventions result in meaningful improvement in its performance as evidenced in repeat measurements of the quality indicators specified for each performance improvement project undertaken by the MCO. The MCO must show that the performance improvement project is working effectively to reach defined quality goals by showing that an improvement occurred; is likely to result in a better outcome for the enrolled population; is attributable to the strength, duration and quality of the MCO's action(s), and not to "confounders" such as chance; and impacts high-volume, high-risk, and/or high-cost conditions or services.

Performance improvement projects are deemed successful and may terminate once sustained improvement is achieved. Sustained improvement is acknowledged through the documentation and maintenance of improved indicator performance. After improvement is achieved, it must be maintained for at least one year. The MCO must submit a corrective action plan that addresses deficiencies identified in any measurement data.

Each performance improvement project must demonstrate effort to achieve meaningful improvement and be completed in a reasonable time period, as determined by BMS. Project reports must be reported by July 15 in order to facilitate the use of resulting data in producing annual information on quality of care. The MCO is required to submit a performance improvement projects progress report 45 days after the end of each quarter. The first quarterly report must be submitted after the first quarter of 2013. The report must follow the BMS-approved format.

#### **6.4 Systemic Problems**

The MCO must correct significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms (such as notice from BMS). The MCO must have written procedures for taking appropriate remedial action whenever inappropriate or substandard services are furnished, or services that should have been furnished were not. These written remedial/corrective action procedures 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.

The MCO must prepare a corrective action plan (CAP) within 30 days of identification to correct any significant systemic problems. As actions are taken to improve care, the MCO must monitor and evaluate these corrective actions to assure that appropriate changes have been made, and track changes in practice patterns. The MCO must conduct follow-up on identified issues to ensure that actions for improvement have been effective.

Information resulting from QAPI activities will be used in recertification, recontracting, and/or annual performance evaluation. QAPI activities must be coordinated with other performance monitoring activities, including utilization management, risk management, and resolution and monitoring of enrollee complaints and grievances. QAPI activities will be linked to other management functions of the MCO, such as network changes, benefits redesign, medical management systems, practice feedback to providers, patient education and member services.

### **6.5 Health Information System**

The 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.

### **6.6 Administration of the QAPI Program**

The MCO's QAPI program must be administered through clear and appropriate administrative arrangements consistent with the Medicaid requirements of 42 CFR §438.240. The MCO must ensure that sufficient resources and staff with necessary education, experience, or training are available to implement the QAPI.

#### ***Written QAPI Program Plan Description***

The MCO must have a written plan describing its QAPI program, including how the MCO will accomplish the activities required by this Section. The QAPI program plan at a minimum must specify clinical or health services delivery areas to be studied that represent the population served by the MCO in terms of age groups, disease categories, and special risk status. The QAPI program plan must describe the MCO's Performance Improvement Projects and any other quality activities that will be undertaken over a prescribed time period. The QAPI program plan must clearly identify the individuals responsible for the activities. Any additional MCO quality activities must use quality indicators that are measurable, objective, and based on current knowledge and clinical experience. The QAPI program plan must define a

methodology and frequency of data collection that assures appropriate and sufficient monitoring to detect need for changes in the QAPI program plan.

### ***Polymaking 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 must meet at least quarterly to oversee QAPI activities and review of the process followed in the provision of health services. Providers must be kept informed about the written QAPI program. Contemporaneous records must document the committee's activities, findings, recommendations, and actions. The QAPI committee will report to the QAPI Policy committee on a scheduled basis on activities, findings, recommendations, and actions. Membership on the QAPI committee must include MCO employed or affiliated providers representative of the composition of the MCO providers. If affiliated providers are not represented on the MCO's QAPI committee or other core coordinating structure, there must be a clinical subcommittee or other advisory group to assure that clinicians actively participate in key activities.

### ***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. The MCO must submit to BMS a written evaluation of its QAPI program strategy by June 15 of each year.

### **6.7 MCO Accreditation**

The MCO must achieve accreditation from the National Committee for Quality Assurance (NCQA) for their Medicaid lines of business by January 1, 2014. The MCO must keep current accreditation from the NCQA for their Medicaid lines of business. The MCO must provide BMS with the accreditation status reports indicating the MCO evaluation option, evaluation measures, evaluation results, and evaluation length. The accreditation reports must be submitted upon completion of each accreditation survey.

Any new MCO entering into this contract after July 1, 2013, must apply for accreditation with NQCA no later than nine months from its operational start date in West Virginia. Any new MCO entering into this contract after July 1, 2013, must become accredited with NQCA within two years of its operational start date in West Virginia. The MCO must provide BMS with the accreditation status reports indicating the MCO evaluation option, evaluation measures, evaluation results, and evaluation length. The accreditation reports must be submitted upon completion of each accreditation survey.

### **6.8 Performance Profiling**

The Department may publish information about MCO performance on a regular basis, identifying the MCO's performance indicators, and comparing that performance to other MCOs and to other external standards and/or benchmarks. The Department will allow the MCO opportunity to review its data for accuracy and/or validity prior to publication.

## **7. FINANCIAL REQUIREMENTS & PAYMENT PROVISIONS**

### **7.1 Solvency Requirements**

The MCO must make provisions against the risk of insolvency and assure that neither enrollees nor BMS are held liable for debts in the event of the MCO's insolvency or the insolvency of any subcontractors.

The MCO must demonstrate adequate initial capital reserves and ongoing reserve contributions in accordance with the Insurance Commissioner's requirements. The MCO must provide financial data to BMS in accordance with BMS' required formats and timing.

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

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.

If the MCO's responsible official determines that payment of the Medicaid Medical Loss Ratio (MLR) rebate by MCO will cause the MCO's risk based capital to fall below levels required by the West Virginia Offices of the Insurance Commissioner, the MCO's responsible official must notify the Department in writing as soon as administratively possible and prior to making any MLR rebate payments to the Department.

## **7.2 Capitation Payments to MCOs**

### ***Time and Manner of Payment***

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 premiums from enrollees. Contract Exhibit B contains a listing of MHT and WVHB capitation rates. The Department will automatically make capitation payments to the MCOs each month based on membership. The Department expects to process payments on the 16<sup>th</sup> and make capitation payments on the 20<sup>th</sup> of each month. MCOs will be required to submit a quarterly invoice to reconcile any differences between the capitation payments made by the Department and actual membership.



The Department 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. The Department 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 Department 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 the Department 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 the Department).

#### ***West Virginia Health Bridge Risk Corridor Payment Adjustment***

Using the Medical Loss Ratio calculation methodology described in the Attachment I of this Contract, the Department will evaluate the total annual capitation payment made to the MCO for West Virginia Health Bridge (WVHB) members and their associated medical costs against a designated Risk Corridor to determine whether a Risk Corridor payment adjustment is warranted. A Risk Corridor is established beginning with a target Medical Loss Ratio (MLR) of eighty-five (85) percent of total capitation paid by the Department on behalf of WVHB members during the State Fiscal Year 2016. If the MCO's WVHB MLR falls outside of the target Risk Corridor range of eighty-five to ninety-five percent, the MCO will be subject to an adjustment to total WVHB capitation payments for the State Fiscal Year 2016.

For medical expenses below eighty-five (85) percent of total capitation paid for WVHB members, no capitation adjustments will be made as the MCO must pay a program rebate to the Department using the methodology per Article III, Section 7.3.

For medical expenses above the upper risk corridor boundary of ninety-five (95) percent, an additional capitation payment from the Department will be made to the MCO for WVHB members. This adjustment will be computed as eighty (80) percent of the difference between the WVHB medical expenses of the MCO and the dollar amount corresponding to the upper Risk Corridor boundary.

### **7.3 Medicaid Medical Loss Ratio**

The MCO is required to maintain a Medical Loss Ratio (MLR) of at least 85 (eighty five) percent during the calendar year reporting period for the Mountain Health Trust and West Virginia Health Bridge programs. The Department will calculate MLR for each MCO program using the methodology as described in Exhibit I of this Contract. .

If the MCO reports a MLR of less than 85 percent for any MCO program, the MCO must pay a program rebate to the Department using the methodology, time and form described in Attachment I of this Contract.

### **7.4 Health Insurer Fee**

The Patient Protection and Affordable Care Act (ACA) Health Insurer Fee (HIF) and resulting income tax non-deductibility will be accounted for through an administrative allowance included in the capitation payment. The percentage allowance was calculated based on publically available estimates of liability. Once each MCO's final liability is known, the State will reconcile that to the amount paid through the capitation payments. If the amount paid is less than the liability amount, an increase will be made to future capitation payments. If the amount paid is greater than the liability amount, a decrease will be made to future capitation amounts.

### **7.5 Incurred But Not Reported (IBNR) Claims**

The MCO must complete and submit the quarterly and annual Incurred But Not Reported (IBNR) claims reports to the Department, using the following schedule and methodology:

1. Due 45 days after the end of each report quarter;
2. Prior quarter and prior year IBNR in dollars, and as a percentage of incurred claims, must be reported;
3. For the prior year IBNR report, any IBNR percentage that exceeds 10% must be expressly addressed, including but not limited to, any of the following reasons:
  - Delayed provider billing;
  - Specific system delays;
  - Seasonality of claim payments/processing;
  - Impact of large claims on the data; and
  - Other factors as assessed by MCO with rationale.

### **7.6 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 must comply with W. Va. C.S.R. §9-5-11 when identifying and collecting third party payments.

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 Third Party Liability (TPL) case that is known to the MCO, the MCO must notify BMS on the 15th of each month by submitting an electronic file, in a format to be specified by BMS, listing these identified TPL cases. For these cases, BMS or its contractor will have the sole and exclusive right to pursue, collect, and retain recoveries of these third party payments.

The MCO must also report TPL information in a file format to be specified by BMS, including status updates on any cases identified for pursuit to BMS on a monthly basis. The MCO must contact BMS if it becomes aware that an enrollee has become eligible for Medicare while on Medicaid. It must also notify BMS as it becomes aware of other insurance coverage.

Confidentiality of the information will be maintained as required by federal regulations, 42 CFR 431 Subpart F and 42 CFR Part 2.

## **7.7 Special Payment Arrangements**

### ***Responsibility for Inpatient Care***

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

- **Disenrollment:** For the MCO member receiving inpatient care at the time of disenrollment from managed care, coverage of inpatient facility charges (including charges at a transfer facility, if the member is transferred during the stay, or within a facility) provided after the effective date of disenrollment will be the responsibility of the MCO until the member is discharged. Coverage of all other covered services (including, but not limited to emergency transportation, professional fees during the inpatient stay and outpatient care) provided during the inpatient stay will be the responsibility of BMS as of the effective date of disenrollment from the MCO. In the case of insolvency, the MCO must cover continuation of services to members for duration of period for which payment has been made, as well as for inpatient admissions up until discharge.
- **MCO Transfer:** For the MCO member receiving inpatient care at the time of transfer to another MCO, coverage of inpatient facility charges (including charges at a transfer facility, if the member is transferred during the stay) provided after the effective date of transfer between the MCOs will be the responsibility of the MCO in which the member was enrolled at the time of the admission, until the patient is discharged from the

inpatient facility. Coverage of all other services (including, but not limited to emergency transportation, professional fees during the inpatient stay and outpatient care) will be the responsibility of the MCO that the member transfers to, as of the effective date of the enrollment into another MCO.

- **Inpatient Transfer:** For the prospective enrollee receiving inpatient care at the time of enrollment into the MCO and who transfers inpatient facilities as part of the same admission, coverage of inpatient facility charges provided after the effective date of the MCO enrollment will be the responsibility of BMS. If a member is discharged and admitted to another inpatient facility, coverage of all services provided at the inpatient care facility will be the responsibility of the MCO.

Article III, Section 7.7, Responsibility for Inpatient Care, does not apply to the behavioral inpatient and residential care services.

### ***Loss of Medicaid Eligibility***

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

### ***Excluded Providers***

In accordance with 42 CFR 1001.1901(c)(5), payment under Medicaid is not available for excluded providers except for emergency medical services or items. To be payable, a claim for such emergency items or services must be accompanied by a sworn statement of the person furnishing the items or services specifying the nature of the emergency and why the items or services could not have been furnished by an individual or entity eligible to furnish or order such items or services. No claim for emergency items or services will be payable if such items or services were provided by an excluded provider who, through an employment, contractual or any other arrangement, routinely provides emergency health care items or services.

### ***Maternity Kick Payments***

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

### ***Authorized, Non-Emergency Out-of-Network Services***

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

### ***Directed Payments to the Certain Qualified Providers***

#### ***Qualified Providers***

For the purposes of this subsection Qualified Providers include:

1. A nonstate, but government owned facility such as a county or city hospital;
2. University Practice Plans (affiliated with a public academic institution);

3. Public safety net hospitals; and
4. Private hospitals, except for the critical access hospitals.

#### *Directed Payments*

The MCO must reimburse Qualified Providers at the minimum levels directed by the Department. The Department must provide the levels for the Directed Payments to the MCO on the State Fiscal Year basis.

#### *Directed Payments Reporting*

The MCO must produce a quarterly report indicating the following:

- Qualified Providers that received Directed Payments;
- Amount per claim paid by the MCO to the Qualified Provider; and
- The date such Directed Payments were made to the Qualified Providers.

#### *Directed Payments Retroactive Adjustment*

During SFY16, the MCO must adjust the amount of Directed Payments to the Qualified Providers at a minimum level otherwise effective July 1, 2015. No retroactive adjustments to the Directed Payments may be issued by the MCO to the Qualified Providers until a retroactive adjustment to the MCO capitation payment has been made by the Department in full.

The Department will not treat such **adjustments** as a violation of the Article III, Section 2.7, Timely Payment Requirement. The MCO must produce an ad-hoc report indicating any adjustments made in a format and time as required by the Department.

### **7.8 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 to the Department. 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.

### ***Coordination with the State***

The MCO must work with BMS, the Medicaid Fraud Control Unit (MFCU), the Office of the Inspector General (OIG) and the Centers for Medicare and Medicaid Services (CMS) to administer effective fraud and abuse practices. 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 designate one primary and one secondary contact person for all BMS Program Integrity and MFCU records requests. BMS or MFCU records requests will be sent to the designated MCO contact person(s) in writing via email, fax, or regular mail and will provide the specifics of the information being requested. The MCO must respond to the appropriate BMS or MFCU staff member within 14 days or within the timeframe designated in the request. If the MCO is unable to provide all of the requested information within the designated timeframe, an extension may be granted and must be requested in writing by the MCO no less than two business days prior to the due date. The data must be provided in the order and format requested.

### ***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 a sample of members, as required in 42 CFR 455.1, including documenting the results of verification activities;
3. Assigning and strengthening internal controls to ensure claims are submitted and payments are made properly;
4. Educating employees, network providers, and beneficiaries about 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 but not limited to the following:

1. Identifying provider fraud and abuse by reviewing for:
  - A lack of referrals;
  - Improper coding (upcoding and unbundling);
  - Patterns of over- or underutilization of pharmacy services;
  - 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.

The MCO must submit a report summarizing the MCO's activities and results of these monitoring analyses for the current state fiscal year to BMS by June 15 of each year.

### ***Fraud and Abuse Reports***

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:

- Provider name/ID number (NPI and MCO ID);

- Date the case was initiated;
- Source of complaint;
- Type of provider;
- Nature of complaint;
- Approximate dollars involved;
- Legal and administrative disposition of case; and
- Status of the reported 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.

The MCO must submit to BMS by the 15th of each month the provider termination report for all in-network terminations for cause and provider credentialing denials for cause during the prior calendar month.

If the MCO refers cases of suspected fraud, waste, or abuse to an entity other than BMS regarding its Medicaid product, the MCO will notify BMS of such referral.

### ***Investigations***

The MCO must cooperate and assist BMS or any State or Federal agency charged with the duty of identifying, investigating, sanctioning, or prosecuting suspected fraud, abuse, or waste. The MCO is responsible for investigating possible acts of waste, abuse, or fraud for all services, including those that the MCO subcontracts to outside entities.

If the MCO identifies that fraud or abuse has occurred in the Medicaid program, based on information, data, or facts, the MCO must immediately notify the BMS Office of Program Integrity (OPI) following the completion of ordinary due diligence regarding a suspected fraud or abuse case. If BMS OPI accepts the case for State investigation, the MCO may not engage in investigation efforts other than coordination efforts with the State. The BMS OPI must supply a notice to the MCO notifying it of the case acceptance status no later than the tenth business day after the MCO notifies the BMS OPI of the suspected fraud or abuse. The MCO may proceed with the investigation or payment recovery efforts if the MCO receives a notice from the BMS OPI and/or the Medicaid Fraud Control Unit (MFCU) indicating that the MCO is authorized to proceed with a case.

If the BMS OPI or the MFCU has assumed responsibility for completion of the investigation and of final disposition of any administrative, civil, or criminal action taken by the State or Federal government, the BMS OPI or MFCU will direct the collection of any overpayment by the MCO.

### ***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 will 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.

## **8.2 Credible Allegation of Provider Fraud**

42 CFR 455.23 requires the State Medicaid Agency to suspend all Medicaid payments to a provider after the Agency determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity unless the agency has good cause not to suspend payments or suspend payment only in part. The rules governing payment suspensions based upon pending investigations of credible allegations of fraud apply to Medicaid managed care entities.

### ***Provider Payment Suspension***

The MCO is required to cooperate with the Department when payment suspensions are imposed for the Medicaid provider by the Department. When Department sends notice that payments to a provider have been suspended, the MCO must also suspend payments to the provider within 1 business day if such provider is in the MCO network and receives payments. When such notice is received from the Department by the MCO, the MCO must respond to the notice within 3 business days and inform the Department of whether the MCO has implemented the suspension.

The MCO must also report all of the following information to the Department monthly: name of the suspended MCO provider, date the suspension was imposed, date the suspension was discontinued, reason for discontinuing the suspension, amount of payments held, and, if applicable, the good cause rationale for not suspending payment (for example, the provider is not enrolled in the MCO's network) or imposing a partial payment suspension. If the MCO does not suspend payments to the provider, the Department may impose contractual remedies.

The Department is responsible for evaluating allegations of fraud and imposing payment suspensions, when appropriate, for those MCO providers who are a part of the State fee-for-service network. The MCO is responsible for initiating payment suspensions based on the credible allegation of fraud for its in-network providers who are not a part the State fee-for-service network. For payment suspensions initiated by the MCO, the MCO must comply with all requirements of 42 CFR 455.23. The MCO report the following information to the Department within 1 business day after suspension: the nature of the suspected fraud, basis for the suspension, date the suspension was imposed, date the suspension was discontinued, reason for discontinuing the suspension, outcome of any appeals, the amount of payments held, and, if applicable, the good cause rationale for imposing a partial payment suspension.

### **8.3 MCO Requirements Related to Information Systems**

The MCO must clearly define and document the policies and procedures that will be followed to support day-to-day systems activities. The MCO must develop and maintain the following documents:

1. Disaster Recovery Plan;
2. Business Continuity Plan;
3. Information Security Plan; and
4. Systems Quality Assurance Plan.

The MCO must provide a copy of these documents within 10 business days of written request from BMS.

## **9. PHARMACY SERVICES**

### **9.1 MCO Pharmacy Service Administration**

The MCO must provide pharmacy-dispensed prescriptions as a covered service.

The MCO may employ the services of a PBM or utilization review agent if such a manager or agent covers the prescription drug benefit equivalent to the requirements described in Exhibit A and in accordance with the state's PDL and drug prior authorization requirements. If the MCO elects to subcontract with a PBM, the MCO must notify the Department of the selected vendor and its ownership.

If the PBM is owned wholly or in part by a retail pharmacy provider, chain drug store, or pharmaceutical manufacturer, the MCO is required to submit a written description of the assurances and procedures that will be used to ensure no conflicts of interest exist and that the confidentiality of proprietary information is maintained. The MCO is required to submit a documented plan for monitoring the subcontractor to the Department.

### **9.2 Preferred Drug List**

The MCO must allow members access to prescribed drugs through a preferred drug list (PDL) developed by the Department. The MCO may not maintain a separate PDL from the Department. PDL drugs must adjudicate as payable without prior authorization, unless they are subject to prior authorization as established by the Department.

A claim for a PDL drug eligible for automated prior authorization (AP) must be adjudicated electronically without a manual review. A pharmacy provider must be informed if its claim does not meet the PDL AP criteria and a manual review is required.

The MCO must achieve a threshold of at least ninety-five (95) percent of the number of prescriptions written for preferred versus non-preferred products per calendar quarter. The MCO must report performance on this measure on a quarterly basis in a format to be specified by the Department.

The Department may require a corrective action for any PDL non-compliance. The Department may impose other remedies under Article II, Section 6 if corrective actions fail to improve PDL compliance.

### **9.3 Prior Authorization Requirements for Prescription Drugs**

The MCO must establish policies and procedures to comply with the Department's prior authorization (PA) criteria in accordance with the PDL guidance for the drugs listed on the PDL.

The MCO must establish criteria and coverage policies for the drugs not listed on the PDL.

The MCO must ensure that decisions regarding policies and procedures for administration of the PDL and non-PDL drugs are made in a clinically sound manner.

The MCO may not require a PA for any drug exempted from PA requirements by federal law.

The MCO must inform the member and prescriber when pharmacy drug administration will require the prescribing provider to request a PA and, if applicable, provide the option of using an alternative medication that may be available without a PA.

The MCO must provide access to a toll-free phone line for prescribers to call to request a

PA for non-PDL drugs or drugs that are subject to PDL PA requirements. For all telephonic and non-telephonic PA requests, the MCO must notify the prescriber's office of a PA denial or approval no later than 24 hours after receipt. If the MCO cannot make a PA determination within 24 hours, the MCO must allow the member to receive a sufficient supply of the medication pending resolution of the PA request.

If the MCO or its PBM operates a separate call center for PA requests, the PA call center must at a minimum meet the provider phone line performance standards set forth in Article III, Section 2.6.

Members may file grievances or appeals related to pharmacy services as described in Article III, Section 3.8. A provider may appeal PA denials on a member's behalf.

If requested by the Department, the MCO is required to submit any information concerning the PA process in accordance with a timeline provided by the Department.

### **9.4 Prescription Drug Limitation**

The MCO must have policies and procedures to comply with the Department's prescription drug limitations, if any. The MCO must be able to recognize those members who are not subject to the prescription drug limitation.

The MCO must educate their members and providers on limitations in prescription drug coverage.

## **9.5 Non-Covered Pharmacy Services**

The MCO must not reimburse for drugs, drug products, and related services, which are defined as a non-covered benefit by the Department's Outpatient Drug Pharmacy Program.

In accordance with 42 U.S.C. § 1396r-8, the MCO must exclude coverage for any drug marketed by a drug company (or labeler) that does not participate in the federal drug rebate program. The MCO is not permitted to provide coverage for any drug product, brand name or generic, legend or non-legend, sold or distributed by a company that did not sign an agreement with the federal government to provide Medicaid rebates for that product.

The MCO must not provide coverage under any circumstances for drug products that have been classified as less-than-effective by the Food and Drug Administration (FDA) Drug Efficacy Study Implementation (DESI).

## **9.6 Emergency Medication**

The MCO must have policies and procedures for dispensing a 72-hour emergency supply of medication. This procedure should not be used for routine and continuous overrides.

A 72-hour emergency supply of prescribed medication must be dispensed any time a Medicaid claim rejects for prior authorization required. The MCO must reimburse the pharmacy for the 72-hour emergency supply.

The MCO must train member services staff about the emergency prescription dispensing process and what steps to take to address problems immediately if pharmacies do not provide a 72-hour emergency supply of medication. The 24-hour member hotline staff must respond immediately to problems concerning emergencies by means at its disposal, including explaining the rules to Medicaid members so that they understand their rights and, if need be, by offering to contact the pharmacy that is refusing to fill the prescription to explain the 72-hour supply policy.

## **9.7 E-Prescribing**

The MCO must support a real time e-prescribing system that allows prescribers and pharmacies to utilize the following functions, at a minimum: eligibility confirmation, PDL benefit confirmation, identification of "alternative" (i.e., preferred) drugs that can be used in place of non-preferred drugs, medication history, and prescription routing. The MCO's system must be certified to accept electronic prescriptions for controlled substances as described in 21 CFR Part 1311.

## **9.8 Mail Order Prescriptions**

The MCO may not include mail-order pharmacies in their networks.

## **9.9 Health Insurance Portability and Accountability Act (HIPAA) Compliance**

The MCO must ensure that all pharmacy eligibility inquiries and claim transactions are compliant with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, P.L. 104-191 (August 21, 1996), as amended or modified.

### **9.10 Disclosures**

The MCO must ensure that all pharmacy providers are licensed in the State of West Virginia or the state in which they operate to provide the services for which the MCO or PBM is contracting, and not be under sanction or exclusion from the Medicaid and Medicare programs.

The MCO must disclose all financial terms and arrangements for remuneration of any kind that apply between the MCO and any prescription drug manufacturer or labeler, including, without limitation, formulary management, drug-switch programs, educational support, claims processing, pharmacy network fees, data sales fees, and any other fees.

### **9.11 Member Fraud and Abuse**

The MCO may implement a pharmacy lock-in program for its members. The program must include policies, procedures and criteria for establishing sufficient evidence for the lock-in. Members must be notified prior to the lock-in and be permitted to choose or change pharmacies for good cause.

The MCO must be able to process a one-time override by the PBM to allow Medicaid payment to a non-lock-in pharmacy.

Valid reasons for an override include, but are not limited to:

- Member recently moved;
- Medication is out of stock;
- Member temporarily in a facility; or
- Member away from home area.

The MCO will periodically evaluate the continued need for lock-in at minimum once per year.

The MCO is required to submit any information to the Department concerning the lock-in policies, procedures, and criteria, if requested. The MCO must submit reports on lock-in participants, if requested by the Department. At a minimum, a lock-in report must include lock-in participant information, pharmacy provider information, and effective dates for the MCO lock-in.

### **9.12 Pharmacy Rebates**

The MCO is not authorized to collect or negotiate rebates with drug companies for preferred pharmaceutical products.

### **9.13 Rebate Disputes**

The MCO must implement a process to support the Department's Medicaid rebate dispute resolution processes. The Department will notify the MCO of claims submitted with incorrect information. The MCO will have 60 days from receipt of the rebate dispute from the Department to correct and resubmit any of the disputed encounters or provide an explanation as to why the encounter was appropriately processed. The MCO must submit responses to disputed encounters in a format to be specified by the Department. The MCO must establish a single point of contact for the Department during the rebate dispute resolution process.

### **9.14 Maximum Allowable Cost Pricing**

The MCO must make available to a contracted pharmacy provider the drugs subject to Maximum Allowable Cost and the actual Maximum Allowable Cost for each drug as follows:

1. The MCO must timely review and make necessary adjustments to the Maximum Allowable Cost (MAC) for every drug;
2. The MCO must update the list of drugs subject to MAC and the actual MAC for each drug at least weekly;
3. The MCO must establish a reasonable process for the prompt weekly notification of any pricing updates to the contracted pharmacy provider;
4. The pharmacy provider contract or the pharmacy provider manual must contain policies and procedures for appeal, investigation, and provider dispute resolution regarding the MAC pricing;
5. The MCO must implement a process to provide for retroactive reimbursements from the MCO to the pharmacy provider or from the pharmacy provider to the MCO arising out of appeals, investigations, and resolution of provider disputes regarding the MAC pricing; and
6. The MCO must submit policies and procedures for appeal, investigation, and provider dispute resolution regarding the MAC pricing to the Department upon the Department's request.

## **10. MHT CHILDREN'S DENTAL SERVICES**

### **10.1 MHT Children's Dental Services Administration <sup>12</sup>**

The MCO must provide Mountain Health Trust children's dental services to individuals under 21 years of age as covered services in an amount, duration, and scope reasonably expected to achieve the purpose for which the services are furnished. The MCO may place appropriate limits on a service on the basis of such criteria as medical necessity or for utilization control, consistent with the terms of this Contract and clinical guidelines.

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<sup>12</sup> West Virginia Health Bridge program provides coverage for emergency dental benefit only. The MCO must cover WVHB members under 21 for the full scope of the dental services under the EPSDT coverage requirements.

The MCO may employ the services of a Dental Contractor serving as a dental benefit manager or utilization review agent if such a manager or agent covers the children's dental benefit equivalent to the requirements described in Exhibit A and in accordance with this Contract. If the MCO elects to employ the services of a Dental Contractor or utilization review agent, the MCO is required to comply with all subcontractor requirements outlined in this Contract.

## **10.2 Covered Dental Services**

The MCO covered services must be provided by a licensed dentist or dental specialist in an office, clinic, hospital, ambulatory setting, or elsewhere when dictated by the need for diagnostic, preventive, therapeutic, or palliative care, or for the treatment of a particular injury as specified in Exhibit A of this Contract. Medicaid children's dental services include diagnostic services, preventive treatment, restorative treatment, endodontic treatment, periodontal treatment, surgical procedures and/or extractions, orthodontic treatment, complete and partial dentures, as well as complete and partial denture relines and repairs. Also included are adjunctive general services, injectable medications, and oral and maxillofacial surgery services.

## **10.3 Dental Director**

The MCO must have a qualified licensed dentist to serve as the Dental Director for the dental benefit. The Dental Director, or his or her designee meeting the qualifications described above, must be available for dental utilization review decisions and must be authorized and empowered to respond to dental clinical issues, utilization review, and dental quality of care inquiries.

## **10.4 Oral Health Fluoride Varnish Program**

The MCO must educate its network providers about the BMS Infant and Child Oral Health Fluoride Varnish Program for Primary Care Practitioners, where certified primary care providers may receive a reimbursement for fluoride varnish application. Providers must complete a certified training course from the WVU School of Dentistry prior to performing and billing the MCO for these services.

## **10.5 Coordination of Care**

Pursuant to 42 CFR 438.208, the MCO is responsible for the management of dental care and continuity of care for all affected MCO members. The MCO or the MCO's PCP must urge members to see their dental provider at least once every six (6) months for regular check-ups, preventive pediatric dental care, and any services necessary to meet the member's diagnostic, preventive, restorative, surgical, and emergency dental needs.

Per Article III, 1.2, the MCO's PCP must coordinate care by providing a direct referral to a dentist for children beginning at 6 months after the first tooth erupts or by 12 months of age as a part of the EPSDT process. Dental screenings are covered for any child under the age of 21 years per the recommended guidelines set forth by the American Academy of Pediatric Dentistry (AAPD) and Bright Futures.

## **10.6 Continuity of Care for MCO Orthodontic Services**

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

## **10.7 Continued Care for Active Orthodontia**

The MCO must ensure, in conjunction with BMS, continuity of care for active orthodontia cases from January 1, 2014, until care is completed and providers are fully reimbursed. The MCO must pay for orthodontic services not previously reimbursed under the fee-for-service as a part of the global payment fee.

The MCO must allow a member to continue receiving orthodontic services with an existing out-of-network provider.

The MCO must maintain written orthodontic continuity of care records.

# **11. BEHAVIORAL HEALTH SERVICES**

## **11.1 MCO Behavioral Services Administration**

The MCO must provide inpatient and outpatient behavioral services as covered services in an amount, duration, and scope reasonably expected to achieve the purpose for which the services are furnished.<sup>13</sup> The MCO may place appropriate limits on a service on the basis of such criteria as medical necessity or utilization control, consistent with the terms of this contract and clinical guidelines.

The MCO may employ the services of a subcontractor serving as a behavioral health benefit administrator or utilization review agent if such administrator or agent covers the behavioral health benefit equivalent to the requirements described in Exhibit A and in accordance with this contract. If the MCO elects to employ the services of a benefit manager or utilization review agent, the MCO is required to comply with all subcontractor requirements outlined in this contract.

## **11.2 Behavioral Health Director**

The MCO must employ or contract with a qualified West Virginia licensed physician to serve as the Behavioral Health Director for the covered behavioral services. When employed or contracted, the Behavioral Director must be available for behavioral utilization review decisions and must be authorized and empowered to respond to behavioral clinical issues, utilization review, and behavioral quality of care inquiries.

## **11.3 Behavioral Health Covered Services**

The MCO covered behavioral services must be rendered by providers within the scope of their license and in accordance with all State and Federal requirements. Behavioral services include:

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<sup>13</sup> 42 CFR § 438.210



mental health outpatient services, mental health inpatient services, substance abuse outpatient services (including but not limited to pharmacologic management and excluding methadone treatment), targeted case management, behavioral health rehabilitation and clinic services, and psychiatric residential treatment services.

#### **11.4 Services Not Covered under Managed Care**

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

- Services provided to individuals under age 21 performed in a Children’s Residential Treatment Facility;
- Services provided in certain alcohol and drug addiction community-based residential treatment facilities to individuals between the ages of 22 and 64 for facilities of 17 beds or more. As restricted per Title XIX of the Social Security Act addressing Medicaid reimbursements to Institutions for Mental Disease (IMD) [42USC 1396d].<sup>14</sup>

#### **11.5 Coordination of Care**

Notwithstanding internal care coordination of care requirements outlined in Article III, Section 5.6 of this Contract, the MCO’s primary care provider must coordinate the member’s health services, as appropriate, with behavioral health providers.

#### **11.6 Adult Inpatient and Residential Care for Behavioral Health**

Article III, 7.6, Responsibility for Inpatient Care, does not apply to the behavioral inpatient and residential care services. Payment liability for behavioral health inpatient services is assigned as follows:

- The MCO is not responsible for any payments for inpatient behavioral health services that are covered by fee-for-service;
- The MCO is responsible for all claims incurred within the inpatient behavioral health treatment settings covered by managed care;
- The MCO is not responsible for claims incurred within the inpatient behavioral health or residential treatment setting if a member entered the treatment setting as a fee-for-service member;
- The MCO is not responsible for claims incurred within the inpatient behavioral health treatment settings if a member entered the treatment setting as a member of another MCO;
- The MCO is not responsible for any claims incurred during inpatient stay at Mildred Mitchell Bateman Hospital and William R. Sharpe Jr. Hospital, if a member is between the ages of 22 and 64;
- The MCO is not responsible for any claims incurred during residential treatment facility stay for individuals 21 years of age or older;

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<sup>14</sup> The State Hospitals are considered IMD facilities.

- Notwithstanding any of the provisions of Article III, Section 11.6, the MCO is responsible for any claims incurred during involuntary inpatient facility stay.

### **11.7 Children’s Inpatient Care for Behavioral Health**

- The MCO is not responsible for any payments for inpatient behavioral health services that are covered by fee-for-service;
- The MCO is responsible for all claims incurred within the inpatient behavioral health or psychiatric treatment settings covered by managed care;
- The MCO is not responsible for claims incurred within the inpatient behavioral health or psychiatric treatment setting if a member entered the treatment setting as a fee-for-service member; and
- The MCO is not responsible for claims incurred within the inpatient behavioral health or psychiatric treatment settings if a member entered the treatment setting as a member of another MCO.

### **1.8 Court Ordered Services**

The MCO is required to reimburse providers for court-ordered treatment services that are covered by the MCO under the Medicaid State Plan; the court order would serve as a binding determination of medical necessity.

### **11.9 Behavioral Health Provider Network**

The MCO must comply with this Section notwithstanding Article III, Section 2 of this Contract.

The MCO must reimburse at least 100 percent of the current fee-for-service Medicaid fee schedule to in-network behavioral health provider, unless such provider agreed to an alternative payment schedule. The Department will notify the MCO of any changes in the fee-for-service Medicaid schedule as soon as administratively possible. The MCO must adjust the reimbursement schedule to in-network behavioral provider within 10 business days of the Department’s notification of any changes in the fee-for-service Medicaid schedule.

### **11.10 Behavioral Health Service Authorization**

In addition to the service authorization requirements outlined in Article III, Section 5.4, the MCO must comply with the Department’s standard behavioral service authorization format. The Department must notify the MCO in writing of any modifications to the standard behavioral service authorization format 5 business day prior to making such modifications.

The MCO may modify the Department’s standard behavioral service authorization format at request of the MCO provider.

## **12. 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 must have in place policies and procedures

for effectively assigning and monitoring activities to those entities. All delegated functions must have a written agreement between the MCO and delegated entity, specifying the delegated activities and reporting responsibilities of the entity and providing for revocation of the delegation or other remedies for inadequate performance. The MCO must evaluate the entity's ability to perform the delegated activities prior to delegation, monitor the entity's performance on an ongoing basis, and formally review performance at least annually. If the MCO identifies deficiencies or areas for improvement, the MCO and the entity must take corrective action. If the MCO delegates selection of providers to another entity, the MCO must retain the right to approve, suspend, or terminate any provider selected by that entity.

## EXHIBIT A: DESCRIPTION OF MCO COVERED AND EXCLUDED SERVICES

The following charts present an explanation of the medical, behavioral, pharmacy, and dental 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. The MCO pharmacy services also must comply with Article III, Section 9 of this contract.

Medicaid benefit packages differ depending on whether the beneficiary is covered under Mountain Health Trust, West Virginia Health Bridge managed care or fee-for-service programs. The following charts present the covered services under each of these benefit packages.

### MCO Covered Services for Mountain Health Trust

MHT MEDICAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Ambulatory Surgical Center Services	Any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization, as well as private practitioners.	Nursing, technicians, and related services. Use of the facilities where surgical procedures are performed; drugs, biologicals, surgical dressings, splints, casts, appliances, and equipment directly related to the provision of the surgical procedure; diagnostic or therapeutic services or items directly related to the provision of a surgical procedure. Materials for anesthesia.	Physician services; lab & x-ray; prosthetic devices; ambulance; leg, arm, back, and neck braces; artificial limbs and DME are excluded.
Cardiac Rehabilitation	A comprehensive outpatient program of medical evaluation, prescribed exercise, cardiac risk factor modification, and education and counseling that is designed to restore members with heart disease to active, productive lives. Cardiac rehabilitation can be performed in a specialized, freestanding physician directed clinic or in an outpatient hospital department.	Supervised exercise sessions with continuous electrocardiograph monitoring. The medically necessary frequency and duration of cardiac rehabilitation is determined by the member's level of cardiac risk stratification.	
Chiropractor Services	Services provided by a chiropractor consisting of manual manipulation of the spine.	Manipulation to correct subluxation. Radiological examinations related to the service.	Certain procedures may have service limits.

MHT 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.	
Diabetes Disease State Management	Patient-centered health care approach to the treatment of individuals who have been diagnosed with Type 1, Type 2, or gestational diabetes mellitus.	Assessment of the member's clinical status; diet management and education, referral to other providers, comprehensive diabetes assessment using a provider care tool.	
Early and Periodic Screening, Diagnoses and Treatment (EPSDT)	Early and periodic screening, treatment, 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. A service need not cure a condition in order to be covered under EPSDT. Services that maintain or improve a child's current health condition are also covered in EPSDT because they "ameliorate" a condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. Services are covered when they prevent a condition from worsening or prevent development of additional health problems.	Limited to individuals under age 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.	All family planning providers, 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.	Provides linkage and coordination of services to all WV children with special needs and limited direct medical services, equipment, and supplies to those families that meet financial and other program eligibility requirements.	Services are provided to children under 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. Recipients age 21 and over waive right to other Medicaid services related to the terminal illness.

MHT MEDICAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
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.
Hospital Services, Outpatient	Medical services furnished on an outpatient basis by a hospital, regardless of the type of provider ordering the service.	Preventive, diagnostic, therapeutic, all emergency services, or rehabilitative medical services.	Services not generally furnished on an inpatient basis by most hospitals in the state. Only technical component of certain services.
Inpatient Rehabilitation	Services related to inpatient facilities that provide rehabilitation services for Medicaid eligible individuals under the age of 21	Services that are medical inpatient rehabilitation services for Medicaid eligible individuals under 21, and general medical outpatient services which meet certification requirements of the Office of Facility, Licensure and Certification .	Limited to individuals under age 21.
Laboratory and X-Ray Services. Non-Hospital	Laboratory and x-ray services provided in a facility other than a hospital outpatient department.	All laboratory and x-ray services ordered and provided by or under the direction of a physician. Includes laboratory services related to the treatment of substance abuse.	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, medical services related to the treatment of substance abuse, and fluoride varnish services. Physician services may be delivered using telehealth.	Certain procedures may have service limits, or require prior authorization. Fluoride varnish services may only be provided to children ages six months to three years.
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 subluxations of the foot are not covered.

MHT MEDICAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Prescription Drugs	Simple or compound substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance.	Prescription drugs dispensed on an ambulatory basis by a pharmacy, family planning supplies, diabetic supplies, vitamins for children to age 21, and prenatal vitamins.	Not Covered: Drugs for weight gain, cosmetic purposes, hair growth, fertility, less than effective drugs and experimental drugs. Hemophilia blood factors are covered by Medicaid fee-for-service. Drugs and supplies dispensed by a physician acquired by the physician at no cost 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 may be 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 orthotics, 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.
Pulmonary Rehabilitation	Individually tailored multidisciplinary approach to the rehabilitation of members who have pulmonary disease.	One-on-one therapeutic procedures to increase strength or endurance of respiratory muscles and functions.	
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.	
Tobacco Cessation	Treatment for tobacco use and dependence.	Diagnostic, therapy, counseling services, quitline services, and pharmacotherapy for cessation. The children's benefit also includes the provision of anticipatory guidance and risk-reduction counseling with regard to tobacco use during routine well-child visits.	
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 Dental Services for Mountain Health Trust

MHTDENTAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
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.
Dental Services (Children )	Services provided by a dentist, orthodontist or oral surgeon or dental group to children under the age of 21.	Emergency and non-emergency: surgical, diagnostic, preventive, and restorative treatment, periodontics, endodontics, orthodontics, prosthodontics, extractions, and complete or partial dentures.	Limited to individuals under age 21.

### MCO Covered Behavioral Services for Mountain Health Trust \*

MHTBEHAVIORAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Behavioral Health Rehabilitation for Individuals Under Age 21, Psychiatric Residential Treatment Facility	Behavioral health rehabilitation performed in a children's residential treatment facility.	Diagnosis, evaluation, therapies, and other program services for individuals with mental illness, mental retardation, and substance abuse.	Procedure specific limits on frequency and units.
Behavioral Health Outpatient Services	Behavioral health clinics, behavioral health rehabilitation, targeted case management, psychologists, and psychiatrists. (Emergency room services are included in the MCO benefits package.)	Diagnosis, evaluation, therapies, 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.
Psychological Services	Services provided by a licensed psychologist in the treatment of psychological conditions.	Evaluation and treatment, including individual, family, and group therapies. Psychological services may be delivered using telehealth.	Evaluation and testing procedures may have frequency restrictions.
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.

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



## MCO Covered Services for West Virginia Health Bridge

WVHB MEDICAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Ambulatory Surgical Center Services	Any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization, as well as private practitioners.	Nursing, technicians, and related services. Use of the facilities where surgical procedures are performed; drugs, biologicals, surgical dressings, splints, casts, appliances, and equipment directly related to the provision of the surgical procedure; diagnostic or therapeutic services or items directly related to the provision of a surgical procedure. Materials for anesthesia.	Physician services; lab & x-ray; prosthetic devices; ambulance; leg, arm, back, and neck braces; artificial limbs and DME are excluded.
Cardiac Rehabilitation	A comprehensive outpatient program of medical evaluation, prescribed exercise, cardiac risk factor modification, and education and counseling that is designed to restore members with heart disease to active, productive lives. Cardiac rehabilitation can be performed in a specialized, freestanding physician directed clinic or in an outpatient hospital department.	Supervised exercise sessions with continuous electrocardiograph monitoring. The medically necessary frequency and duration of cardiac rehabilitation is determined by the member's level of cardiac risk stratification.	
Chiropractor Services	Services provided by a chiropractor consisting of manual manipulation of the spine.	Manipulation to correct subluxation. Radiological examinations related to the service.	Certain procedures may have service limits.
Clinic Services	Preventive, diagnostic, therapeutic, rehabilitative, or palliative services furnished by a clinic (that is not part of a hospital) on an outpatient basis.	General clinics, birthing centers and health department clinics, including vaccinations for children.	
Diabetes Disease State Management	Patient-centered health care approach to the treatment of individuals who have been diagnosed with Type 1, Type 2, or gestational diabetes mellitus.	Assessment of the member's clinical status; diet management and education, referral to other providers, comprehensive diabetes assessment using a provider care tool.	
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.	All family planning providers, 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 individuals 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.

<b>WVHB MEDICAL SERVICE</b>	<b>DEFINITION</b>	<b>SCOPE OF BENEFITS</b>	<b>LIMITATION ON SERVICES</b>
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. Recipients age 21 and over waive 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.
Hospital Services, Outpatient	Medical services furnished on an outpatient basis by a hospital, regardless of the type of provider ordering the service.	Preventive, diagnostic, therapeutic, all emergency services, or rehabilitative medical services.	Services not generally furnished on an inpatient basis by most hospitals in the state. Only technical component of certain services.
Inpatient Rehabilitation	Services related to inpatient facilities that provide rehabilitation services for Medicaid eligible individuals.	Services that are medical inpatient rehabilitation services for Medicaid eligible individuals, and general medical outpatient services which meet certification requirements of the Office of Facility, Licensure and Certification .	
Laboratory and X-Ray Services. Non-Hospital	Laboratory and x-ray services provided in a facility other than a hospital outpatient department.	All laboratory and x-ray services ordered and provided by or under the direction of a physician. Includes laboratory services related to the treatment of substance abuse.	Must be ordered by physician. Certain procedures may have service limits.
Nurse Practitioners' Services	Services provided by a nurse midwife, nurse anesthetist, family or pediatric nurse practitioner.	Specific services within specialty.	Certain procedures may have service limits.
Other Services Speech Therapy Physical therapy Occupational Therapy	NA	Treatment or other measures provided by speech, physical or occupational therapists to correct or ameliorate any condition within the scope of their practice.	Hearing aid evaluations, hearing aids, hearing aid supplies, batteries and repairs .Certain procedures may have service limits, or require prior authorization.
Physician Services	Services of a physician to a 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, medical services related to the treatment of substance abuse, and fluoride varnish services. Physician services may be delivered using telehealth.	Certain procedures may have service limits, or require prior authorization. Fluoride varnish services are not available for adults.
Podiatry Services	Foot care services.	Treatment for acute conditions, i.e. infections, inflammations, ulcers, bursitis, etc. Surgeries for bunions, ingrown 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 sublocations of the foot are not covered.

WVHB MEDICAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Prescription Drugs	Simple or compound substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance.	Prescription drugs dispensed on an ambulatory basis by a pharmacy, family planning supplies, diabetic supplies, vitamins for children to age 21, and prenatal vitamins.	Not Covered: Drugs for weight gain, cosmetic purposes, hair growth, fertility, less than effective drugs and experimental drugs. Hemophilia blood factors are covered by Medicaid fee-for-service. Drugs and supplies dispensed by a physician acquired by the physician at no cost 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 may be required.
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 orthotics, 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.
Pulmonary Rehabilitation	Individually tailored multidisciplinary approach to the rehabilitation of members who have pulmonary disease.	One-on-one therapeutic procedures to increase strength or endurance of respiratory muscles and functions.	
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.	
Tobacco Cessation	Treatment for tobacco use and dependence.	Diagnostic, therapy, counseling services, quitline services and pharmacotherapy for cessation. The children's (under 21) benefit also includes the provision of anticipatory guidance and risk-reduction counseling with regard to tobacco use during routine well-child visits.	
Transportation, Emergency	Transportation to secure medical care and treatment on a scheduled or emergency basis.	Emergency ambulance and air ambulance.	Emergency transportation provided to the nearest resource. By most economical means determined by patient needs. 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 (under 21)-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 Dental Services for West Virginia Health Bridge

WVHB DENTAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Dental Services <sup>15</sup>	Services provided by a dentist, orthodontist, or oral surgeon.	Emergency services only.	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.

### MCO Covered Behavioral Services for West Virginia Health Bridge \*

WVHB BEHAVIORAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Behavioral Health Rehabilitation for Individuals Under Age 21; Psychiatric Residential Treatment	Behavioral health rehabilitation performed in a children's residential treatment facility.	Diagnosis, evaluation, therapies, and other program services for individuals with mental illness, mental retardation, and substance abuse.	Procedure specific limits on frequency and units.
Behavioral Health Outpatient Services	Behavioral health clinics, behavioral health rehabilitation, targeted case management, psychologists, and psychiatrists. (Emergency room services are included in the MCO benefits package.)	Diagnosis, evaluation, therapies, 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.
Psychological Services	Services provided by a licensed psychologist in the treatment of psychological conditions.	Evaluation and treatment, including individual, family, and group therapies. Psychological services may be delivered using telehealth.	Evaluation and testing procedures may have frequency restrictions.
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

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

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

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<sup>15</sup> The MCO must cover WVHB members under 21 for the full scope of the dental services under the EPSDT coverage requirements.

## 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 ectopic pregnancy.	Written physician certification of medical necessity. All Federal and State laws regarding this benefit must be adhered to.
Early Intervention Services for Children Three 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.	
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, 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.
Personal Care Services	Medically necessary activities or tasks ordered by a physician, which are implemented according to a Nursing Plan of Care developed and supervised by a registered nurse. These services enable people to meet their physical needs and be treated by their physicians as outpatients, rather than on an inpatient or institutional basis.	Services include those activities related to personal hygiene, dressing, feeding, nutrition, environmental support functions, and health-related tasks.	Room and board services, services which have not been certified by a physician on a Personal Care Medical Eligibility Assessment (PCMEA) or are not in the approved plan of medically necessary care developed by the registered nurse, hours that exceed the 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.
School-based Services	Services provided by a physical therapist, speech therapist, occupational therapist, nursing care agency, or audiologist in a school-based setting.	Services provided in a school-based setting.	Limited to individuals under age 21. Refer to the FFS Medicaid provider manuals for an explanation of service limitations.

MEDICAL SERVICE	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
Transportation, Non-emergency	Non-ambulance medical transportation to and from Medicaid covered scheduled medical appointments.	Includes transportation via multi-passenger van services and common carriers such as public railways, buses, cabs, airlines, and private vehicle transportation by individuals.	Prior authorization by BMS is required for multi-passenger van services. Prior authorization by county DHHR staff is required for transportation by common carriers.

### **Abortion Services**

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

**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 B: OVERVIEW OF WEST VIRGINIA'S SFY 2016  
MOUNTAIN HEALTH TRUST AND WEST VIRGINIA HEALTH BRIDGE  
PAYMENT METHODOLOGY AND CAPITATION RATES**

**(attached under separate cover)**



## EXHIBIT C: SERVICE AREAS

(as applicable for each MCO)

**CoventryCares of West Virginia's (CCWV's) service area consists of the following counties:**

County	CCWV Service Area
Barbour	X
Berkeley	X
Boone	X
Braxton	X
Brooke	X
Cabell	X
Calhoun	X
Clay	X
Doddridge	X
Fayette	X
Gilmer	X
Grant	X
Greenbrier	X
Hampshire	X
Hancock	X
Hardy	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
Mineral	X
Mingo	X
Monongalia	X
Monroe	X
Morgan	X
Nicholas	X
Ohio	X
Pendleton	X
Pleasants	X
Pocahontas	X
Preston	X

<b>County</b>	<b>CCWV Service Area</b>
Putnam	X
Raleigh	X
Randolph	X
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

***The Health Plan of the Upper Ohio Valley's (THP's) service area consists of the following counties:***

<b>County</b>	<b>THP Service Area</b>
Barbour	X
Berkeley	X
Boone	X
Braxton	X
Brooke	X
Cabell	
Calhoun	X
Clay	X
Doddridge	X
Fayette	X
Gilmer	X
Grant	X
Greenbrier	X
Hampshire	X
Hancock	X
Hardy	X
Harrison	X
Jackson	X
Jefferson	X
Kanawha	X
Lewis	X
Lincoln	X
Logan	X
Marion	X
Marshall	X

<b>County</b>	<b>THP Service Area</b>
Mason	X
McDowell	X
Mercer	X
Mineral	X
Mingo	X
Monongalia	X
Monroe	X
Morgan	X
Nicholas	X
Ohio	X
Pendleton	X
Pleasants	X
Pocahontas	X
Preston	X
Putnam	X
Raleigh	X
Randolph	X
Ritchie	X
Roane	X
Summers	X
Taylor	X
Tucker	X
Tyler	X
Upshur	X
Wayne	
Webster	X
Wetzel	X
Wirt	X
Wood	X
Wyoming	X

**UniCare Health Plan of West Virginia's (UniCare's) service area consists of the following counties:**

<b>County</b>	<b>UniCare Service Area</b>
Barbour	X
Berkeley	X
Boone	X
Braxton	X
Brooke	X
Cabell	
Calhoun	X
Clay	X
Doddridge	X
Fayette	X
Gilmer	X

<b>County</b>	<b>UniCare Service Area</b>
Grant	X
Greenbrier	X
Hampshire	X
Hancock	X
Hardy	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
Mineral	X
Mingo	X
Monongalia	X
Monroe	X
Morgan	X
Nicholas	X
Ohio	X
Pendleton	X
Pleasants	X
Pocahontas	X
Preston	X
Putnam	X
Raleigh	X
Randolph	X
Ritchie	X
Roane	X
Summers	X
Taylor	X
Tucker	X
Tyler	X
Upshur	X
Wayne	
Webster	X
Wetzel	X
Wirt	X
Wood	X
Wyoming	X

**West Virginia Family Health's (WVFH's) service area consists of the following counties:**

<b>County</b>	<b>WVFH Service Area</b>
Barbour	X
Berkeley	X
Boone	X
Braxton	X
Brooke	X
Cabell	
Calhoun	X
Clay	X
Doddridge	X
Fayette	X
Gilmer	X
Grant	X
Greenbrier	X
Hampshire	X
Hancock	X
Hardy	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
Mineral	X
Mingo	X
Monongalia	X
Monroe	X
Morgan	X
Nicholas	X
Ohio	X
Pendleton	X
Pleasants	X
Pocahontas	X
Preston	X
Putnam	X
Raleigh	X
Randolph	X
Ritchie	X

<b>County</b>	<b>WVFH Service Area</b>
Roane	X
Summers	X
Taylor	X
Tucker	X
Tyler	X
Upshur	X
Wayne	
Webster	X
Wetzel	X
Wirt	X
Wood	X
Wyoming	X

## **EXHIBIT D: MARKETING POLICIES**

Applicable Legal Authorities:

42 U.S.C. §1396u-2

42 CFR §438.104

The MCO is required to comply with the Marketing Policies as they relate to Medicaid or West Virginia Health Bridge (WVHB) and Mountain Health Trust (MHT) programs. All Marketing Policies are applicable to the MCO, its agents, subcontractors, and providers. The Marketing Policies, Exhibit D may be amended by the Department at any time and changes will be distributed to the MCO.

Violation of any of the Marketing Policies is subject to remedies, as outlined in this Contract.

### **General Marketing Standards**

The MCO may conduct general advertising that does not specifically solicit the Medicaid population. Member enrollment will be handled by the Department through a contract with a central enrollment broker.

The MCO must submit to the Department for prior written approval a marketing plan and all marketing materials prepared pursuant to said plan and this Contract. General member health education brochures and member health education materials do not require approval from the Department. The Department will review the marketing plan and all marketing materials as soon as possible but within 45 days to ensure compliance with this Contract. The MCO agrees to engage only in marketing activities that are pre-approved in writing by the Department.

### **Approved Marketing Practices**

The list of approved Marketing practices is not intended to be exhaustive. The following list is applicable to the MCO, its agents, subcontractors, and MCO providers:

1. The MCO is allowed to send outreach materials and non-Marketing correspondence to its members. The content of such mailings must be approved by the Department prior to distribution;
2. Terms such as "choose," "pick," "join," etc. are allowed in marketing materials as long as the Enrollment Broker contractor's telephone number is included;
3. The MCO may send plan specific materials to potential members at the potential member's request. The content of such mailings must be approved by the Department prior to distribution;
4. The MCO may only provide plan specific information during incoming calls from potential members. The MCO may return telephone calls to potential members only when requested to do so by the caller. The content of such call scripts must be approved by the Department prior to distribution;
5. The MCO may respond to direct questions from potential members with accurate information during such telephone calls;

6. The MCO may survey their former and currently enrolled members;
7. The MCO may provide Gifts approved by the Department to encourage currently enrolled members to participate in the surveys;
8. The MCO may distribute materials and information that purely educate its members on the importance of completing the State's Medicaid eligibility renewal process in a timely fashion; and
9. At the Departments' approval, the MCO may provide information about a Qualified Health Plan (QHP) to potential members who could enroll in such a plan as an alternative to the Medicaid managed care plan due to a loss of Medicaid eligibility or to potential members who may consider the benefits of selecting an Medicaid managed care plan that has a related QHP in the event of future eligibility changes. Such information may not be included within Marketing materials.

### **Prohibited Marketing Practices**

A MCO engaging in prohibited Marketing practices listed below will be in violation of this Contract and Marketing Policy. This list is not intended to be exhaustive.

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

1. Distributing Marketing materials without prior Department approval;
2. Using the word, "Mountain," or phrase, "Mountain Health," "Health Bridge", except when referring to Mountain Health Trust, West Virginia Health Bridge or other State programs;
3. Distributing Marketing materials written above the 6th grade reading level, unless approved by the Department;
4. Offering gifts valued over \$15.00 to potential members;
5. Providing gifts to providers for the purpose of distributing them directly to the MCO's potential members or currently enrolled members;
6. Directly or indirectly, engaging in door-to-door, telephone, and other Cold Call Marketing activities;
7. Marketing in or around public assistance offices, including eligibility offices;
8. Using spam (an unwanted, disruptive commercial message posted on a computer network or sent by email);
9. Making any assertion or statement (orally or in writing) that the MCO is endorsed by CMS, a federal or state government agency, or similar entity;
10. Knowingly marketing to persons currently enrolled in another MCO directly by mail, phone or electronic means of communication;
11. Inducing or accepting a member's MCO enrollment or MCO disenrollment;
12. Using terms that would influence, mislead, or cause potential members to contact the MCO, rather than the Enrollment Broker, for enrollment;



13. Portraying competitors in a negative manner;
14. Using absolute superlatives (e.g., “the best,” “highest ranked,” “rated number 1”) unless they are substantiated with supporting data provided to the Department;
15. Making any written or oral statements containing material misrepresentations of fact or law relating to the MCO’s plan or the Medicaid program, services, or benefits;
16. Making potential member gifts conditional based on enrollment with the MCO;
17. Charging members for goods or services distributed at MCO or Medicaid events;
18. Charging members a fee for accessing the MCO’s website;
19. Influencing enrollment in conjunction with the sale or offering of any private insurance;
20. Tying enrollment in the Medicaid MCO with purchasing (or the provision of) other types of private insurance;
21. Using marketing agents who are paid solely by commission;
22. Posting MCO-specific, non-health related materials or banners in provider offices;
23. Conducting potential member orientation in common areas of providers’ offices;
24. Allowing providers to solicit enrollment or disenrollment in an MCO, or distribute MCO-specific materials at a Marketing activity (This does not apply to health fairs where providers do immunizations, blood pressure checks, etc. as long as the provider is not soliciting enrollment or distributing plan specific MCO materials.);
25. Purchasing or otherwise acquiring mailing lists from third party vendors, or for paying Department’s contractors or subcontractors to send plan specific materials to potential members;
26. Referencing the commercial component of the MCO in any Marketing materials;
27. Discriminating against a member or potential member because of race, age, color, religion, natural origin, ancestry, marital status, sexual orientation, physical or mental disability, health status or existing need for medical care, with the following exception: certain gifts and services may be made available to members with certain diagnoses;
28. Assisting with Medicaid MCO enrollment form;
29. Making false, misleading or inaccurate statements relating to services or benefits of the MCO or Medicaid program, or relating to the providers or potential providers contracting with the MCO; and
30. Direct Mail Marketing to potential members.

### **Reporting and Investigating MCO Marketing Violations**

The MCO must establish a process to ensure fair and consistent investigation of alleged violations of the Department’s Marketing Policies.

Upon written receipt of any alleged MCO violation(s) from the Department, the MCO must:

1. Acknowledge receipt, in writing, within one business day from the date of the receipt of the alleged violation.

2. Begin investigation of the alleged violation and complete investigation within fourteen (14) calendar days from the date of the receipt of the alleged violation.
3. Analyze the findings of the investigation and report findings to the Department.

### **Provider Training**

The MCO is required to inform its network providers of the Marketing policies.

### **Gifts to Potential Members**

MCOs may provide promotional gifts valued at or under \$15.00 to potential MCO members. MCOs may distribute promotional gifts valued at more than \$15.00 to current members only. A gift worth \$15 or less must be based on the retail purchase price of the gift item. The MCO may not provide gifts to providers for the purpose of distributing them potential members, unless such gifts are placed in the providers' office common areas and are available to all patients.

### **MCO Member Gifts**

The MCO may solicit its currently enrolled members for participation in MCO health-related activities.

The MCO may provide Gifts valued at \$50.00 or less per member per gift to encourage member attendance or participation in MCO health-related activities. Member Gifts may not be converted to cash. The MCO must not exceed the total annual limit of \$150.00 per each member for all Gifts. The Department must provide prior approval of all monetary and non-monetary compensation provided to members in exchange for participating in MCO activities.

## EXHIBIT E: SUMMARY OF MHT AND WVHB MCO REPORTING REQUIREMENTS

Note: Where the due date states 30 days, the MCO is to provide the deliverable by the last day of the month following the end of the reporting period.

Where the due date states 45 days, the MCO is to provide the deliverable by the 15th day of the second month following the end of the reporting period.

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

Reporting Requirement	Timeframe				Due Date
	Monthly	Quarterly	Annually	Other	
<b>Quarterly reports</b>					
MHT/WVHB-1: Enrollment and Membership Report		X			Within 45 days of end of quarter (by the 15th day of the second month following the end of the reporting period)
MHT/WVHB-2: Provider Network Status Report		X			
MHT/WVHB-3: Claims Processing		X			
MHT/WVHB -4: Experience Summary		X			
MHT/WVHB -5: Medical Grievance and Appeals Report		X			
MHT/WVHB -5a Pharmacy Grievances		X			
MHT/WVHB -5b Dental Grievance and Appeals Report		X			
MHT/WVHB 6: Lag Tables		X			
MHT/WVHB -7: Summary of Claims Paid Outside Encounter Data and Sub-Capitation Arrangements		X			
MHT/WVHB -7a: Experience Summary for Capitated Arrangements		X			
MHT/WVHB -8: Summary of Total Dollars		X			
MHT/WVHB -9: Summary of Total Dollars for Encounter Data		X			
MHT/WVHB- 10 Summary of Co-Pays - by Service Type		X			
MHT/WVHB -11: Member and Provider Services Functions		X			
MHT/WVHB -12: Member Access to Care		X			
MHT/WVHB -13: EPSDT Reporting		X			
MHT/WVHB -14: Medicaid-Related Financial Reports (Statement of Revenue and Expenses)		X			
MHT/WVHB -15 CAHPS Action Plan Progress		X			
MHT/WVHB -16 Out-of-Network Utilization Report		X			
<b>Quality</b>					
Written Description of PIPs and Results			X		July 15
PIP Progress Report		X			Within 45 days of end of quarter
HEDIS			X		On or before June 15 (audited)

Reporting Requirement	Timeframe				Due Date
	Monthly	Quarterly	Annually	Other	
QAPI Annual Evaluation Report Including Status and Results			X		On or before June 15
QAPI Corrective Action Plan				X	Within 30 days of identification of systemic problem
CAHPS Member Survey Analysis and Action Plan		X	X		Annual analysis is due on or before August 15. Quarterly updates are due within 45 days of end of quarter
Accreditation Review Report				X	Upon completion or change in status
Encounter Data	X				Within 30 days of end of month
Adult and Child Core Quality Measures			X		On or before September 1
<b>Providers</b>					
Provider Network Data	X				Electronic provider directories to be submitted to AHSI monthly
Provider Network Adequacy				X	PCP changes -14 days, Hospital changes –immediately, Material changes affecting service delivery-14 days.
Credible Allegation of Fraud – Provider Payment Suspension	X				The 15th of each month (to include all events from the prior month)
<b>Financial reporting</b>					
Annual Financial Statements			X		On or before June 1
Offices of the Insurance Commissioner 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
PCP Payment Methodology				X	Upon request from BMS
MHT and WVHB MLR Audited Reports and Calculations		X	X		Within 45 days of end of quarter and 3 months after December 31
MHT MLR Ad-Hoc Report				X	Due 30 days after the corresponding calendar year performance withhold capitation payment, if any, is distributed to the MCO by the Department
IBNR Claims Report		X	X		Within 45 days of end of quarter and annual report is due on or before August 15
<b>Federal reporting</b>					
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)

Reporting Requirement	Timeframe				Due Date
	Monthly	Quarterly	Annually	Other	
Disclosure of Ownership Reporting			X	X	On or before July 1, or 35 days upon request, or 35 days upon change in ownership
Fraud and Abuse Compliance Plan			X		On or before October 1
FQHC/RHC Quarterly Payment Reports		X			Within 45 days of end of quarter
<b>Other State Required Reporting</b>					
MCO Annual Report				X	On or before April 1
Business Continuity Plan				X	Within 10 business days of BMS written request
Disaster Recovery Plan				X	Within 10 business days of BMS written request
Information Security Plan				X	Within 10 business days of BMS written request
System Quality Assurance Plan				X	Within 10 business days of BMS written request
Sexually Transmitted Diseases			X		Submit attestation by October 1
Tuberculosis			X		Submit attestation by October 1
Communicable Diseases			X		Submit attestation by October 1
Organization Chart			X		On or before October 1
Marketing Plan			X		On or before October 1
Subcontractor Monitoring Plan				X	Within 10 business days of BMS written request
Data Accuracy and Completeness Plan			X		On or before October 1
Analyses and Results of Provider/Beneficiary Utilization to Detect Fraud and Abuse			X		On or before June 15

**EXHIBIT F 1: DATA CERTIFICATION FORM**

**STATE OF WEST VIRGINIA  
MOUNTAIN HEALTH TRUST OR  
WEST VIRGINIA HEALTH BRIDGE  
DATA CERTIFICATION FOR \_\_\_\_\_ REPORT SUBMISSION**

Date Of Data Submission: MM/DD/YYYY

Managed Care Program Type: \_\_\_\_\_

Data Submitted to: \_\_\_\_\_  
Name of Agency Official

\_\_\_\_\_  
Agency/Division

Method Of Data Transmission:  Electronic  Hard Copy

I hereby certify that, in my belief and to the best of my knowledge (based on all information available to me), the data contained in the \_\_\_\_\_ <name of report> \_\_\_\_\_ Report submission by <MCO> \_\_\_\_\_ is accurate, complete, and truthful, and that it has no known or suspected material limitations or imperfections unless described in detail in a statement provided with this submission.

I further certify that I have authority\* to sign this certification on behalf of \_\_\_\_\_ <MCO> \_\_\_\_\_.

Certified by\*: \_\_\_\_\_  
Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date of Submission^

^ Data certification must be submitted concurrently with the certified data (42 CFR 438.606(c)).

\* Certification must be signed by the MCO's Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who has delegated authority to sign for and who reports directly to the MCO's CEO or CFO (42 CFR 438.606(a)).

**EXHIBIT F 2: DATA CERTIFICATION FOR MONTHLY ENCOUNTER DATA  
REPORT SUBMISSION**

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

Date Of Data Submission: MM/DD/YYYY  
Managed Care Program Type: \_\_\_\_\_  
Data Submitted to: \_\_\_\_\_  
Name of Agency Official  
\_\_\_\_\_   
Agency/Division

Method Of Data Transmission:  Electronic  Hard Copy

I hereby certify that, in my belief and to the best of my knowledge (based on all information available to me at the time such data was submitted), the data contained in the MCO MedEncs\_YYYYMM\_YYYYMM.txt report submission by MCO Name was accurate, complete, and truthful, and that it had no known or suspected material limitations or imperfections unless described in detail in a statement provided with that submission.

I further certify that I have authority\* to sign this certification on behalf of MCO.

Certified by\*:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name

\_\_\_\_\_  
Title

MM/DD/YYYY  
Date

^ Data certification must be submitted concurrently with the certified data (42 CFR 438.606(c)).

\* Certification must be signed by the MCO's Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who has delegated authority to sign for and who reports directly to the MCO's CEO or CFO (42 CFR 438.606(a)).

## EXHIBIT G: MOUNTAIN HEALTH TRUST (MHT) PERFORMANCE WITHHOLD

Beginning July 1, 2015, the Department will place each MCO at risk for five percent (5%) of the MHT program capitation payment by withholding that amount from the monthly MHT capitation paid to the MCO by the Department under Article III, 7.2. The Department will follow the measures and methodology outlined below and in Article III, 6.2 of this contract.

The MCO will receive a portion of the withheld MHT program capitation if it meets or exceeds the targeted benchmark on the selected performance measures or targets. Each measure is worth up to 0.625percent of the MHT capitation based on the MCO's performance, using the following evaluation system:

Percentage of Total Capitation Payment Earned Back per Measure	Target/Goal
0.00%	Under the targeted benchmark
0.3125%	Equal to the targeted benchmark
0.3750%	Greater than or equal to 1 percentage point above the targeted benchmark
0.4375%	Greater than or equal to 2 percentage points above the targeted benchmark
0.5000%	Greater than or equal to 3 percentage points above the targeted benchmark
0.5625%	Greater than or equal to 4 percentage points above the targeted benchmark
0.6250%	Greater than or equal to 5 percentage points above the targeted benchmark

The first pay out under the performance withhold program will occur no later than November 2016 and will be based on MCO performance during calendar year 2015. During SFY16, the MCOs must begin measuring all of the selected measures for the performance withhold program. The following measures and benchmarks were identified for the program:

Performance Measures	Targeted Benchmark	Data Collection Method / Methodology
1. Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	National Medicaid Average from 2015 NCQA Quality Compass <sup>16</sup>	Healthcare Effectiveness Data and Information Set (HEDIS)
2. Adolescent Well-Care Visits	National Medicaid Average from 2015 NCQA Quality Compass	HEDIS
3. Immunizations for Adolescents - Combination 1	National Medicaid Average from 2015 NCQA Quality Compass	HEDIS
4. Medication Management for People With Asthma (75% Compliance) – Ages 5 to 64	National Medicaid Average from 2015 NCQA Quality Compass	HEDIS

<sup>16</sup> The 2015 NCQA Quality Compass lists calendar year 2014 rates.



<b>Performance Measures</b>	<b>Targeted Benchmark</b>	<b>Data Collection Method / Methodology</b>
5. Prenatal and Postpartum Care – Postpartum Care	National Medicaid Average from 2015 NCQA Quality Compass	HEDIS
6. Annual Monitoring for Patients on Persistent Medications - Total	National Medicaid Average from 2015 NCQA Quality Compass	HEDIS
7. Adult BMI Assessment	National Medicaid Average from 2015 NCQA Quality Compass	HEDIS
8. Medical Assistance With Smoking and Tobacco Use Cessation (MSC) – Advising Smokers to Quit	National Medicaid Average from 2015 NCQA Quality Compass	HEDIS

If MCO's MHT membership data does not meet a sufficient sample size as defined by Healthcare Effectiveness Data and Information Set (HEDIS), the reporting for such performance measure(s) with insufficient sample size may be waived by the Department. In case the reporting is waived for one or more performance measures, the greater weight of the capitation withhold will go to the remaining performance measures.

## EXHIBIT H: DELIVERABLES/LIQUIDATED DAMAGES MATRIX

### Mountain Health Trust and West Virginia Health Bridge

#	Program Non-Performance	Measurement Period	Liquidated Damages
1	Failure to submit required reports, documentation, ad hoc reports, data certification forms, or any other data required within the timeframes provided by this contract or by the Department. The MCO may have a one business day grace period following the due date of the data, report, or form. Article II, 4.12, unless otherwise specified in this Exhibit.	Ongoing	\$250 per day per each item that is overdue until the satisfactory submission of the required report, documentation, ad hoc report, data certification form, or data required to meet any State or federal reporting requirements After three (3) instances of non-performance during the contract period, the amount is increased by \$1,000 per day per each item that is overdue.
2	Failure to comply with encounter data submission requirements including the failure to address or resolve problems with encounter records in a timely manner as required by Article III, 5.11.	Monthly	\$1,000 per single encounter file per reporting period.
3	Failure to resolve at least 98% of member appeals within 45 calendar days from the date the appeal is filed with the MCO, unless an enrollee requests an extension or the MCO shows that a delay is necessary and in the interest of the enrollee. Article III, 3.8.	Quarterly	\$1,000 for each percentage point below 98% if the MCO fails to meet the standard.
4	Failure to respond to the State drug rebate disputes within 60 days as described in Article III, 9.13.	Ongoing	\$35 per single NDC drug code submitted in each claim.
5	Failure to notify affected members of program or service site changes, at least fourteen calendar days before the intended effective date of the change. Article III, 3.4.	Ongoing	\$250 per each incident per affected member.
6	Failure to report timely to BMS significant network changes as described in Article III, 2.1, Network Changes.	Ongoing	\$500 per incident of non-compliance.

#	Program Non-Performance	Measurement Period	Liquidated Damages
7	Failure to meet provider credentialing requirements, including background screening requirements, specified in Article III, 2.1, Provider Qualification and Selection.	Ongoing	\$500 per incident of non-compliance.
8	Failure to comply with the marketing requirements, or engagement in prohibited marketing practices. Article III, 3.1 and Exhibit D.	Ongoing	\$1,000 per each incident of non-compliance.
9	Failure to pay 7% annual interest on the same date as an in-network clean claim that remained unpaid beyond the 30-day claims payment deadline. Article III, 2.7, Timely Payment Requirement.	Quarterly	\$500 per each in-network clean claim for which the interest remained unpaid on the same date as a claim's payment.
10	Failure to provide timely MCO covered service as described in the Exhibit A of this Contract when, in the determination of BMS, such failure results in actual harm to a member or places a member at risk of imminent harm.	Ongoing	\$7,500 per day for each incident of non-compliance.
11	Failure to provide timely service authorization (prior authorization) as described in Article III, Section 5.4 or a failure to honor service authorization as described in Article III, Section 5.4, Continuity of Care.	Ongoing	\$5,000 per incident of noncompliance.
12	Failure to reimburse a pharmacy for providing a 72-hour emergency supply as outlined in Article III, 9.6 or failure to make a prior authorization determination within 24 hours of the request without providing sufficient amount of the emergency medication supply as outlined in Article III, Section 9.3.	Ongoing	\$5,000 per incident of noncompliance.

## **EXHIBIT I: MEDICAL LOSS RATIO REPORTING AND REBATE METHODOLOGY**

Exhibit I of this Contract outlines the requirements for the Mountain Health Trust (MHT) and West Virginia Health Bridge (WVHB) Medical Loss Ratio (MLR) reporting and for calculating any program rebate amounts that may be due to the Department in the event the MCO does not meet the minimum 85% MLR standard as provided by Article III, Section 7.3 of this Contract. This contractual methodology is based on the methodology described in 45 CFR 158.

### ***Applicable Definitions***

Direct Paid Claims – claim payments before ceded reinsurance and excluding assumed reinsurance except as otherwise provided in this Exhibit.

Health Insurer Fee – see Article III, Section 7.4 of this Contract.

MLR Rebate Year – calendar year during which core benefits and services are provided to the MHT or WVHB program members through the MCO.

Unpaid Claim Reserves – reserves and liabilities established to account for claims that were incurred during the MLR rebate year but had not been paid within 3 months of the end of the MLR Rebate Year.

### ***General Requirements***

The MCO must demonstrate its ongoing contract compliance with the MHT and WVHB MLR standards, as set by Article III, Section 7.3 of this Contract. The MCO must complete and submit the MHT and WVHB MLR Financial Reports to the Department, using the following schedule:

1. Quarterly, due 45 days after the end of the report quarter;
2. Annually, due 3 months following the end of each reported MLR Rebate Year (calendar year); and
3. Ad-hoc MHT MLR report and calculation, due 30 days after the corresponding calendar year performance withhold capitation payment, if any, is distributed to the MCO by the Department.

The MCO must utilize an external auditor to validate its annual MLR Financial Reports. The MCO must calculate its annual MLR for each MCO program. The annual MLR calculations are due at the same time as the annual MLR Financial Reports.

The MLR rebate, if any, is due to the Department in full 60 days after the Department notifies the MCO in writing of any MLR rebate amount due.

The MHT program rebate is assessed using the MLR calculation as provided by the MHT ad-hoc MLR Financial Report submitted to the Department. The WVHB program rebate is assessed using the MLR calculation provided by the WVHB annual Financial Report submitted to the Department.

The MCO must maintain and make available to the Department upon request any data used to calculate MLRs and MLR rebates under this Exhibit together with all supporting information required to determine the methods for calculations outlined in this Exhibit.

### **Calculating MHT and WVHB MLRs**

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

The MLR is the ratio of the Numerator to the Denominator, as defined in this Exhibit. The MLR must be rounded to three decimal places. For example, if an MLR is 0.7988, it must be rounded to 0.799 or 79.9 percent. If an MLR is 0.8253 or 82.53 percent, it must be rounded to 0.825 or 82.5 percent.

#### ***Numerator***

The numerator of an MLR must include total incurred medical expenses defined as follows:

1. Reimbursement for clinical services.
2. Additional adjustments are allowed as applicable:
  - a. State subsidized stop loss payments.
  - b. Provider incentive or bonus payments.
  - c. Administrative expense activities that improve health care quality.
  - d. Health Information Technology meaningful use expenses.
  - e. New member experience deferred from the prior MLR Rebate Year.

The Numerator may not include:

1. Claims that are recoverable for anticipated coordination of benefits.
2. Third party recoveries.
3. Amounts paid to third party vendors for secondary network savings.
4. Other amounts paid to third party vendors for administrative services. If the MCO contracts with a vendor, or a benefit manager, and such vendor reimburses the provider at one amount but bills the MCO a higher amount to cover its network development, utilization management costs, and profits, then the amount that exceeds the reimbursement to the provider must not be included in incurred claims.
5. Pharmacy rebates collected by MCO for non-PDL medications.
6. Provider overpayments recovered.
7. Administrative expense exclusions, except for the costs associated with auditing and certification of the annual MLR Financial Report required by the Department.
8. Prior MLR Rebate Year rebates paid to the Department.

### ***Reimbursement for Clinical Services (Numerator)***

Each MLR calculation must include direct claims paid to or received by providers, whose services are covered by the contract for clinical services or supplies. In addition, the report must include claim reserves associated with claims incurred during the MLR period, the change in contract reserves, reserves for contingent benefits and the claim portion of lawsuits, and any experience rating refunds paid or received. Reimbursement for clinical services is also referred to as “incurred claims”.

1. Incurred claims must include changes in unpaid claims between the prior MLR reporting period and the current MLR reporting period unpaid claims reserves, including claims reported in the process of adjustment, percentage withholds from payments made to MCO providers, claims that are recoverable for anticipated coordination of benefits (COB), and claim recoveries received as a result of third party recoveries.
2. Incurred claims must include the change in claims incurred but not reported from the prior MLR reporting period to the current MLR reporting period. Except where inapplicable, the reserve should be based on past experience and modified to reflect current conditions, such as changes in exposure, claim frequency or severity.
3. Incurred claims must include changes in other claims-related reserves.
4. Incurred claims must exclude rebates paid to the Department based upon prior MLR reporting period experience.

### ***Activities that Improve Health Care Quality (Numerator)***

The MCO must account for expenditures for activities that improve health care quality, as described in this Exhibit.

Activities conducted by the MCO to improve quality must meet the following requirements:

- (1) The activity must be designed to:
  - (i) Improve health quality.
  - (ii) Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements.
  - (iii) Be directed toward individual members or incurred for the benefit of specified segments of members or provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-members.
  - (iv) Be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations.
- (2) The activity must be primarily designed to:
  - (i) Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among MCO specified populations.

(A) Examples include the direct interaction of the MCO (including those services delegated by contract for which the MCO retains ultimate responsibility under this Contract), providers and the member or the member's representative (for example, face-to-face, telephonic, web-based interactions or other means of communication) to improve health outcomes, including activities such as:

- (1) Effective case management, care coordination, chronic disease management, and medication and care compliance initiatives including through the use of the medical homes model as defined in section 3502 of the Affordable Care Act.
- (2) Identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence based medicine.
- (3) Quality reporting and documentation of care in non-electronic format.
- (4) Health information technology to support these activities.
- (5) Accreditation fees directly related to quality of care activities.

(ii) Prevent hospital readmissions through a comprehensive program for hospital discharge.

Examples include:

- (A) Comprehensive discharge planning (for example, arranging and managing transitions from one setting to another, such as hospital discharge to home or to a rehabilitation center) in order to help assure appropriate care that will, in all likelihood, avoid readmission to the hospital;
- (B) Patient-centered education and counseling.
- (C) Personalized post-discharge reinforcement and counseling by an appropriate health care professional.
- (D) Any quality reporting and related documentation in non-electronic form for activities to prevent hospital readmission.
- (E) Health information technology to support these activities.

(iii) Improve patient safety, reduce medical errors, and lower infection and mortality rates.

(A) Examples of activities primarily designed to improve patient safety, reduce medical errors, and lower infection and mortality rates include:

- (1) The appropriate identification and use of best clinical practices to avoid harm.
- (2) Activities to identify and encourage evidence-based medicine in addressing independently identified and documented clinical errors or safety concerns.
- (3) Activities to lower the risk of facility-acquired infections.
- (4) Prospective prescription drug utilization review aimed at identifying potential adverse drug interactions.
- (5) Any quality reporting and related documentation in non-electronic form for activities that improve patient safety and reduce medical errors.
- (6) Health information technology to support these activities.

(iv) Implement, promote, and increase wellness and health activities:

(A) Examples of activities primarily designed to implement, promote, and increase wellness and health activities, include –

- (1) Wellness assessments;
- (2) Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements;
- (3) Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition;
- (4) Public health education campaigns that are performed in conjunction with State or local health departments;
- (5) Actual gifts or incentives that are not already reflected in claims;
- (6) Any quality reporting and related documentation in non-electronic form for wellness and health promotion activities;
- (7) Coaching or education programs and health promotion activities designed to change member behavior and conditions (for example, smoking or obesity); and
- (8) Health information technology to support these activities.

(v) Enhance the use of health care data to improve quality, transparency, and outcomes and support meaningful use of health information technology.

Expenditures and activities that must not be included in quality improving activities are:

- (1) Those that are designed primarily to control or contain costs;
- (2) Those which otherwise meet the definitions for quality improvement activities but which were paid for with other funding separate from capitation revenue;
- (3) Those activities that can be billed or allocated by a provider for care delivery and which are, therefore, reimbursed as clinical services;
- (4) Establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims, including maintenance of ICD-10 code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended.
- (5) That portion of the activities of health care professional hotlines that does not meet the definition of activities that improve health quality;
- (6) All retrospective and concurrent utilization review;
- (7) The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network, including fees paid to a vendor for the same reason;
- (8) Provider credentialing;
- (9) Marketing expenses;



- (10) That portion of prospective utilization that does not meet the definition of activities that improve health quality; and
- (11) Any function or activity not expressly included in this Exhibit, unless otherwise approved by and within the discretion of the Department, upon adequate showing by the MCO that the activity's costs support the definitions and purposes in this part or otherwise support monitoring, measuring or reporting health care quality improvement.

***Expenditures Related to Health Information Technology (HIT) and Meaningful Use Requirements (Numerator)***

The MCO may include activities that improve health care quality such Health Information Technology (HIT) as expenses that are required to accomplish the activities allowed in this Contract and that are designed for use by MCO, its providers, or members for the electronic creation, maintenance, access, or exchange of health information, as well as those consistent with Medicaid meaningful use requirements, and which may in whole or in part improve quality of care, or provide the technological infrastructure to enhance current quality improvement or make new quality improvement initiatives possible by doing one or more of the following:

1. Making incentive payments to providers for the adoption of certified electronic health record technologies and their “meaningful use” as defined by the United States Department of Health and Human Services (HHS), to the extent such payments are not included in reimbursement for clinical services as defined by this Exhibit;
2. Implementing systems to track and verify the adoption and meaningful use of certified electronic health records technologies by health care providers, including those not eligible for Medicaid incentive payments;
3. Providing technical assistance to support adoption and meaningful use of certified electronic health records technologies;
4. Monitoring, measuring, or reporting clinical effectiveness including reporting and analysis of costs related to maintaining accreditation by nationally recognized accrediting organizations such as NCQA or URAC, or costs for public reporting of quality of care, including costs specifically required to make accurate determinations of defined measures (for example, CAHPS surveys or chart review of HEDIS measures) and costs for public reporting mandated or encouraged by law.
5. Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes.
6. Advancing the ability of enrollees, providers, issuers or other systems to communicate patient centered clinical or medical information rapidly, accurately and efficiently to determine patient status, avoid harmful drug interactions or direct appropriate care, which may include electronic health records accessible by enrollees and appropriate providers to monitor and document an individual patient's medical history and to support care management.

7. Reformatting, transmitting or reporting data to national or international government-based health organizations for the purposes of identifying or treating specific conditions or controlling the spread of disease.
8. Provision of electronic health records, patient portals, and tools to facilitate patient self-management.

### ***New Member Experience***

New members assigned to the MCO within a calendar year, are those members that have not been continuously enrolled in the same MCO. Continuous enrollment is defined, for this purpose, as being enrolled for a minimum of 11 months in a calendar year, including enrollment months prior to the current calendar year. Enrollment spans must be separated by 63 days or more to qualify as separate enrollment spans; intervening months must be included in the monthly count in determining the total months of continuous eligibility if comprised of 62 days or less. HEDIS rules for continuous enrollment do not apply for MLR Rebate calculation purposes.

Continuous enrollment is determined based on the MCO enrollment, and may not consider changes in category of eligibility, region, or age/ gender classification as changes to enrollment spans.

If fifty percent or more of the total earned MCO capitation premiums for the MLR Rebate Year is attributable to new member experience and with less than 12 months of experience in the MLR Rebate Year, then the experience for these members may be excluded from the MLR Rebate calculation for that same MLR Rebate Year. If MCO chooses to defer reporting of newer experience as provided in this section, then the excluded experience must be added to the experience reported in the following MLR Rebate Year.

If new member experience percentage is less than fifty percent from the total earned MCO capitation for an MLR Rebate Year, all of the MCO membership must be included in the current MLR Rebate Year calculation.

### ***Denominator***

The Denominator of a reported program MLR calculation must include:

1. Total annual capitation revenue allocated under the Exhibit B of this Contract to that MLR Rebate Year or other reporting period;
2. Corresponding year performance withhold capitation revenue paid to the MCO (if known); and
3. Any delivery kick payments and any other pass through payments paid to the MCO during the MLR Rebate Year or other reporting period.

The Denominator of a reported program MLR calculation may exclude:

1. Premium taxes;
2. Licensing and regulatory fees; and
3. Health Insurance Fee (HIF).

The following denominator adjustments may apply:

1. The MCO may subtract the New Member capitation for the current MLR Rebate Year.
2. The MCO may add the New Member capitation deferred from the prior MLR Rebate Year.

***Rebating Capitation Payments: 85% Medical Loss Ratio Standard is Not Met***

For each MCO program and each MLR Rebate Year, the MCO must provide a rebate to the Department if the MCO does not meet the 85% MLR standard requirement.

Beginning July 1, 2015 and ongoing, the MCO must rebate to the Department the difference between the total amount of capitation revenue received by the MCO during the MLR Rebate Year for each MCO program, less any adjustments (see Denominator), multiplied by the difference between the target MLR of 85 percent and the MCO's annual MLR as calculated in accordance with the methodology provided by this Exhibit.

## **EXHIBIT J: BEHAVIORAL HEALTH TRANSITION**

### **Operational Phase Requirements (OPR)**

This exhibit describes the requirements for the Transition Phase of the existing MHT Medicaid behavioral health benefits carve-in and includes those activities that must take place during the first 90 days after the operational start date. The Transition Phase is defined as the time period starting July 1, 2015, and ending on October 1, 2015, and includes the readiness review activities preceding the benefit transition. The Transition Population (Transition Member) is defined as the MHT Medicaid population (member) receiving behavioral benefits under fee-for-service prior to July 1, 2015, and receiving behavioral benefits under managed care after that date. This attachment expires on October 1, 2015, or when the Transition Phase is deemed completed by BMS, whichever is later.

The MCO has overall responsibility for the timely and successful completion of each of the transition phase operational requirements and any related readiness review activities that support the Transition Phase operational requirements. The MCO must have hardware, software, network, and communications systems with the capability and capacity to handle and operate all systems and subsystems supporting service delivered to the Transition Population. The MCO is required to comply in a timely manner with the additional BMS reporting requirements during the Transition Phase or when the transition requirement is deemed completed by BMS, whichever is later.

The MCO must work with BMS, providers, and members to promptly identify and resolve problems identified after the operational start date and to communicate to BMS, providers, and members, as applicable, the steps the MCO is taking to resolve the problems. If the MCO makes assurances to BMS of its readiness to meet contract requirements, including systems and operational requirements, but fails to satisfy requirements as assured by the MCO, BMS may, at its discretion, do any of the following in accordance with the severity of the non-performance and the impact on members and providers:

1. Suspend new members enrollment into the MCO or
2. Impose other contractual remedies as described in Article II, Section 6.

#### **OPR. 1**

The MCO is responsible for payment for non-emergency behavioral services provided to a Transition Member by out-of-network and in-network providers if such services did not require authorization under fee-for-service. If such services required authorization and were not authorized under fee-for-service, the MCO may deny payments.

#### **OPR. 2**

During the Transition Phase, the MCO must not require any additional prior authorization requirements for behavioral services previously authorized under fee-for-service unless otherwise provided by this Attachment. All authorized fee-for-service prior authorizations are valid for the entire duration of the prior-authorizations.

**OPR. 3**

If fee-for-service prior authorizations expire during the Transition Phase, the MCO must treat the behavioral services renewal authorization as a new prior authorization request subject to the MCO's prior authorization standards where the standards have to be the same or less restrictive than under fee-for-service during the Transition Phase.

**OPR. 4**

During the Transition Phase, the MCO may not impose any additional behavioral services documentation or utilization control requirements beyond those that previously existed in fee-for-service unless such documentation or utilization controls are necessary to prevent Medicaid fraud or abuse.

**OPR. 5**

The MCO may not conduct medical necessity reviews of the behavioral services authorized under fee-for-service during or after the Transition Phase unless such reviews are necessary to prevent Medicaid fraud or abuse.

**OPR. 6**

If, after the Transition Phase, the MCO institutes prior authorization requirements, documentation or utilization controls beyond those that existed in fee-for-service, the MCO must notify affected Transition Population fourteen (14) calendar days prior to the end of the Transition Phase.

**OPR. 7**

The MCO must mail member ID cards to the Transition Members no later than five (5) business days after the operational start date on July 1, 2015.

**OPR. 8**

The MCO must educate its Transition Members on how to obtain behavioral services if they have not received the member ID cards.

**OPR. 9**

For Transition Members, the MCO must mail the updated member handbook sections related to behavioral services no later than fourteen (14) calendar days prior to the operational start date on July 1, 2015.

**OPR. 10**

The MCO must update the Provider Directory sections related to behavioral services no later than 30 days prior to the operational start date on July 1, 2015.

**OPR. 11**

The MCO must assess its current call center capacity during the readiness review phase. The MCO may increase staffing for the MCO call center during the Transition Phase. The MCO must provide BMS with a written explanation if the MCO's call center staff capacity remains unchanged during the Transition Phase.

**OPR. 12**

The MCO must expedite credentialing of behavioral services providers prior to and during the Transition Phase.

**OPR. 13**

The MCO must submit all additional Transition Phase reports in a format and within a timeframe required by BMS. Failure to comply with the reporting requirements will be subject to remedies per Article II, Section 6 and Exhibit H of this Contract.

**OPR. 14**

At the minimum, MCO must submit the following reports:

- Biweekly behavioral health network report: the MCO must report on their behavioral health networks on a biweekly basis until all gaps are sufficiently addressed. Information that must be reported in the biweekly report includes:

Psychiatrist and psychologist standards	<ul style="list-style-type: none"> <li>• Number of the existing contracted providers by provider type by region</li> <li>• Number of the new contracted providers by provider type by region</li> <li>• Number of the new pending contract providers by provider type by region</li> <li>• Number of providers by provider type by region missing</li> </ul>
Geographical access standards	<ul style="list-style-type: none"> <li>• Counties not meeting geographical access standards by provider type</li> <li>• For non-compliant counties, list of providers that are being involved in the contacting efforts and impact on margin of adequacy by the involved providers</li> </ul>
High volume provider standards	<ul style="list-style-type: none"> <li>• Number of FFS high-volume providers contracted by facility type</li> <li>• List of FFS high-volume providers not contracted with, including status of contracting efforts</li> </ul>
All types	<ul style="list-style-type: none"> <li>• The MCO is required to produce a monthly report that indicates behavioral health provider network changes and evaluates the margin of adequacy.</li> </ul>

- Utilization of non-participating providers: the MCO must track out-of-network providers utilized by members for services and must report such utilization on a monthly basis.
- Overall utilization of services: the MCO must report key utilization measures for behavioral health services on a weekly basis for the first month post go-live and bi-weekly for subsequent two months of the transition. The findings in these reports will be compared to the utilization for other benefits provided through the MCO and to national utilization patterns for the behavioral health benefit to ensure members are obtaining services.

- Grievances and appeals: MCO must report grievances and appeals for members receiving behavioral health services. This data will identify any potential barriers to care and will be collected on a monthly basis during the transition phase or beyond.
- Customer service: MCO must report the standard key measures on responsiveness to members. This data will help to identify any systematic issues members are having in accessing service and will be collected on a weekly basis for the first month post go-live and bi-weekly for the subsequent two months of the transition.